Supreme Court, U.S.
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In The
Supreme Court of the United States

STEPHANIE ELLIOT,

Petitioner,

v.

FORTIS BENEFITS INSURANCE CO.,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Does the Employee Retirement Income Security Act's remedies provision, 29 U.S.C. § 1132, nullify Montana's right under the McCarran-Ferguson Act to prohibit unfair and anti-competitive insurance company claims adjusting practices despite ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A), and interpretive clause, 29 U.S.C. § 1144(d)?

PARTIES TO THE PROCEEDING

The parties to this proceeding are:

Stephanie Elliot, an individual; and

Fortis Benefits Insurance Company, a corporation

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CITATIONS OF OPINIONS AND ORDERS ENTERED IN THIS CASE

1. *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138 (9th Cir. 2003).
2. *Elliot v. Fortis Benefits Ins. Co.*, No. CV 01-11-BLG-RFC (D. Mont. Nov. 7, 2001).
3. *Elliot v. Fortis Benefits Ins. Co.*, No. CV 01-11-BLG-RFC (D. Mont. Dec. 20, 2001).

BASIS FOR SUPREME COURT JURISDICTION

The Court of Appeals for the Ninth Circuit entered its judgment on August 1, 2003. *Appendix at 1.* Petitioner Stephanie Elliot seeks review of that judgment on a writ of certiorari. This Court has jurisdiction under 28 U.S.C. § 1254(1) to review on a writ of certiorari the judgment of a federal court of appeals. This petition is timely filed under 28 U.S.C. § 2101(c) and under Rule 13.3 of this Court.

FEDERAL AND STATE STATUTORY PROVISIONS INVOLVED IN THIS CASE

29 U.S.C. § 1132 (Appendix at 41); 29 U.S.C. § 1144 (Appendix at 52); M.C.A. § 33-18-101 (Appendix at 58); M.C.A. § 33-18-102 (Appendix at 58); M.C.A. § 33-18-201 (Appendix at 59); M.C.A. § 33-18-242 (Appendix at 60).

STATEMENT OF THE CASE

I. Brain and Bone Cancer Disabled Ms. Elliot.

Stephanie Elliot suffered from breast cancer in 1995. *Appendix at 83-87.* Fortunately, the extensive treatment she received, including a right mastectomy, chemotherapy, and a stem-cell transplant, proved successful and by July 1996 Ms. Elliot had completely recovered. Then, for prophylactic purposes, her oncologists prescribed the drug Tamoxifen for Ms. Elliot to take. *Appendix at 138-140.* Tamoxifen is an anti-estrogen drug that significantly reduces the risk that cancer will develop in the future.

After she had recovered, Ms. Elliot underwent routine, periodic tests to check for cancer. From July 1996 until she began working for the Crowley Law Firm as a paralegal in September 1999, Ms. Elliot remained cancer free. In June 2000, Ms. Elliot's oncologist summarized her condition at that time by stating, "Stevie in the three years I have followed her has remained disease free." *Appendix at 144.*

On September 27, 1999, Ms. Elliot started work for the Crowley Law Firm and was enrolled in the firm's group long term disability policy with Fortis Benefits Insurance Company. *Appendix at 88-90.* The Crowley Law Firm and Ms. Elliot each paid a portion of her monthly premium. The Fortis policy excluded coverage for pre-existing conditions for one year. *Appendix at 119.* The policy defined a pre-existing condition as "an injury, sickness, or pregnancy or any related injury, sickness, or pregnancy" for which the insured had received advice or treatment during the three months before the insured became enrolled in the Fortis group policy. *Id.* The policy's pre-existing condition exclusion ended once an insured had

been continuously insured under the group policy for twelve consecutive months. *Id.*

On August 19, 2000, Ms. Elliot fainted while shopping. She was taken to the emergency room where CT scans and an MRI revealed brain and bone cancer. Ms. Elliot has been totally disabled since August 19, 2000 and is terminally ill.

Ms. Elliot received short-term disability benefits from the Crowley Law Firm for ninety days. On October 17, 2000, she applied for long-term disability benefits under the Fortis policy with payments to begin effective November 21, 2000. *Appendix at 88-90.* At that time, Ms. Elliot had been continuously insured under the Fortis policy for over twelve consecutive months.

II. Fortis Violated M.C.A. § 33-18-201 in Denying Ms. Elliot's Claim For Disability Benefits.

Upon receiving her claim, Fortis initially informed Ms. Elliot, who was critically ill, that she would not be eligible for disability benefits until she returned to active work for at least one day. *Appendix at 141.* To support its position, Fortis purported to quote language from its policy with the Crowley Law Firm that imposed this requirement. The policy, however, contained no such language. *Compare letter, Appendix at 141 with policy, Appendix at 119.*

After obtaining her medical records, Fortis denied Ms. Elliot's claim. *Appendix at 72-77.* Fortis asserted that because Ms. Elliot had been taking Tamoxifen during the three months before she started working at the Crowley Law Firm, she must have had cancer as a pre-existing

condition. Fortis then claimed that because Ms. Elliot's disability was caused by a pre-existing condition, she was not entitled to benefits.

Nothing in Ms. Elliot's medical records, however, supported Fortis' assertion that her oncologists were prescribing Tamoxifen to treat cancer. In fact, when Ms. Elliot was diagnosed with cancer following her fainting spell in August 2000, her doctors immediately discontinued her Tamoxifen. *Appendix at 30.* Ms. Elliot did not have cancer, or any other sickness or disease, during the three months before she became insured under Fortis' policy. *Appendix at 139.*

To make matters worse, Fortis refused to address or acknowledge that its policy excluded coverage for disabilities caused by pre-existing conditions for only one year. *Appendix at 72-77.* The uncontradicted facts demonstrated that Ms. Elliot had been continuously insured under the Fortis policy for twelve consecutive months when she applied for disability benefits. Fortis never explained why it was asserting the pre-existing condition exclusion to deny Ms. Elliot's claim when that exclusion only applied for the first year Ms. Elliot was insured.

III. Ms. Elliot Sued to Recover Disability Benefits and for Damages Caused By Fortis' Violations of M.C.A. § 33-18-201.

Ms. Elliot filed suit against Fortis on January 19, 2001. *Appendix at 64-77.* Her complaint set forth two claims for relief. In Count I, Ms. Elliot sought disability benefits and attorneys fees and costs pursuant to ERISA, 29 U.S.C. § 1132. In Count II, Ms. Elliot sought compensatory and punitive damages for Fortis' violation of

Montana's Unfair Trade Practices Act (UTPA), M.C.A. § 33-18-201 and 242.[1] By misrepresenting the Crowley Law Firm policy provisions, by asserting without any factual basis that Ms. Elliot had cancer during the summer of 1999, and by ignoring the one year limitation on the policy's pre-existing condition exclusion,. Fortis used unfair and deceptive claims adjusting practices to deny Ms. Elliot's claim, thereby violating subsections 1, 4, and 6 of M.C.A. § 33-18-201. Fortis answered the complaint by denying that Ms. Elliot was entitled to disability benefits and by asserting that Ms. Elliot's UTPA claims were preempted by ERISA. *Appendix at 78-82.*

Ms. Elliot was the principal source of income for her family. Fortis' denial of disability benefits was economically devastating to her and her family. On May 30, 2001, Ms. Elliot had to use her last $300.00 to prevent her electricity from being turned off. *Appendix at 63.* When informed of this, Fortis started paying benefits, but persisted by motion and argument to the Court that Ms. Elliot was not entitled to any disability benefits.

The District Court held that Fortis' denial of Ms. Elliot's claim for disability benefits was without merit. The District Court stated that:

> . . . the medical records are uncontroverted and demonstrate that plaintiff did not have cancer between July of 1997 and September 27, 1999. It is also undisputed that plaintiff was prescribed,

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[1] Montana's UTPA prohibits an insured from suing an insurer for bad faith. M.C.A. § 33-18-242(3) ("An insured may not bring an action for bad faith in connection with the handling of an insurance claim.")

> and took, Tamoxifen to lessen the chances of breast cancer reoccuring in the future. It was not prescribed to treat active disease or sickness.

Appendix at 30. In awarding attorney's fees and costs, the District Court further stated that:

> As noted in the Court's order, the position of Fortis as to the interpretation of the policy was without merit. The medical evidence showed the plaintiff had no cancer. She was at the time taking a preventative medication to prevent further occurrences of cancer. Determining that these facts constituted a "preexisting condition" was an abuse of discretion and consequently the arguments by the defendant had no merit.

Appendix at 39.

With respect to Ms. Elliot's UTPA claims, the District Court held that, under the Ninth Circuit's decision in *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 812 (9th Cir. 1992), Montana's UTPA statutes were civil enforcement provisions that did not regulate insurance. The District Court ruled that ERISA preempted Ms. Elliot's UTPA claims. *Appendix at 26-28.* Ms. Elliot appealed.

Using a different analysis, the United States Court of Appeals for the Ninth Circuit held that ERISA's civil remedies provision preempted Ms. Elliot's UTPA claims. *Appendix at 18.* The Ninth Circuit did not decide whether Montana's UTPA statutes were laws that regulated insurance and, thereby, saved from preemption under ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A). *Appendix at 13-15.* Instead, the Ninth Circuit held that ERISA's civil remedies provision, 29 U.S.C. § 1132, independently

preempted Ms. Elliot's UTPA claims because Montana's UTPA statutes provided a remedy not listed in § 1132. *Appendix at 17-18.* In short, the Ninth Circuit held that ERISA's civil remedies provision could itself preempt a state law regulating insurance that would otherwise be saved from preemption under ERISA's savings clause.

ARGUMENT

I. Summary of Argument for Review of the Ninth Circuit's Decision.

By holding that ERISA's civil remedies provision, 29 U.S.C. § 1132, independently preempts Montana's Unfair Trade Practices Act, the Ninth Circuit has nullified ERISA's savings clause; has abrogated Montana's right under the McCarran-Ferguson Act to regulate the claims adjusting practices of insurers who issue employer-sponsored life, health, or disability policies; and has disregarded this Court's precedent for deciding ERISA preemption issues. The Ninth Circuit's decision also conflicts with ERISA preemption decisions from the United States Court of Appeals for the Second Circuit and the Third Circuit.

In effect, the Ninth Circuit's decision allows insurers who issue policies for employer-sponsored welfare benefit plans in Montana to use unfair and deceptive adjusting practices to deny claims with impunity, thereby subverting Congress's goal of safeguarding employee pension and welfare benefits. Insurers that use prohibited adjusting practices, in turn, gain an unfair competitive advantage through the illicit profits that those adjusting practices generate. In response, other insurers must either adopt the same prohibited practices or become less competitive.

Unless effectively regulated, prohibited adjusting practices spread like a virus from insurer to insurer through economic necessity. The Ninth Circuit's decision effectively prevents Montana from maintaining a fair and level playing field on which insurers can compete.

This Court has not yet decided the issue of whether a state law that regulates insurance, and is thereby saved from preemption by ERISA's savings clause, can be independently preempted by ERISA's civil remedies provision. The Ninth Circuit's decision squarely presents this issue for the first time. Its resolution raises important federal questions about whether states can regulate insurance company claims adjusting practices to protect the millions of employees insured by employer-sponsored life, health, and disability policies. For, if the Ninth Circuit's decision stands, states in the Ninth Circuit can no longer protect those employees from unfair and deceptive claims adjusting practices.

II. ERISA Preserves a State's Right Under the McCarran-Ferguson Act to Regulate Claims Adjusting Practices.

Under the McCarran-Ferguson Act, 15 U.S.C. § 1012, Congress reserved to the States the power to regulate the business of insurance. 15 U.S.C. § 1012(2) expressly states that, "No Act of Congress shall be construed to invalidate, impair, or supercede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." In *Sec. & Exch. Commn. v. Natl. Sec.*, 393 U.S. 453, 460 (1969), this Court identified the core features of the business of insurance as follows:

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement – these were the core of the 'business of insurance.' Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was – on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly are laws regulating the "business of insurance."

In later decisions, this Court specifically recognized that an insurer's claims adjusting practices are a critical component of the business of insurance. *See, e.g., Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 134 n. 8, 137-138 (1982) (Both majority and dissent agree that claims adjustment activities are central to the business of insurance.); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 728 n. 2 (1985) ("Laws regulating aspects of transacting the business of group insurance include, for example, those regulating claims practices or rates."); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 375 n. 5 (1999) (Laws regulating claims practices are typical of the state laws that regulate insurance.).

As described by this Court, ERISA's purpose is "to promote the interests of employees and their beneficiaries in employee benefits plans." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983). While ERISA comprehensively

regulates pension plans, ERISA "does not regulate the substantive content of welfare-benefit plans."[2] *Metropolitan*, 471 U.S. at 732. Nor does ERISA regulate the claims adjusting practices of insurers who issue life, health, or disability insurance policies for welfare benefit plans. Through its savings clause, ERISA leaves the regulation of claims adjusting practices to the states under the McCarran-Ferguson Act.

ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A), states that: "Except as provided in subparagraph (B),[3] nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities." To reconcile its interpretation with other federal laws, such as the McCarran-Ferguson Act, ERISA further provides that, "Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supercede any law of the United States . . . or any rule or regulation issued under any such law." 29 U.S.C. § 1144(d). Though ERISA also contains a preemption clause that states that ERISA "shall supersede . . . state laws" that "relate to any employee benefit plan," 29 U.S.C. § 1144(a), this Court has recognized that ERISA's savings clause is "phrased with similar breadth" and "exempts from preemption 'any law of any State which regulates insurance.'" *UNUM v. Ward*, 526 U.S. at 363.

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[2] Employers provide group life, health, and disability insurance through welfare benefit plans.

[3] Subsection (B) is the "deemer" clause which does not apply in this case because Ms. Elliot's disability benefits were being provided through insurance as opposed to her employer's self-funded plan.

III. ERISA's Civil Remedies Provision, 29 U.S.C. § 1132, Cannot be Construed to Trump ERISA's Savings Clause.

On its face, ERISA's savings clause saves from preemption any state law that regulates insurance. In light of the McCarran-Ferguson Act and the states' traditional powers to regulate insurance, this Court has refused to narrow the scope of the savings clause. *UNUM*, 526 U.S. at 363. This Court's test has been straightforward: "If a state law 'regulates insurance,' . . . it is not preempted." *Metro. Life*, 471 U.S. at 746. This Court has never held that ERISA's civil remedies provision, 29 U.S.C. § 1132, can independently preempt a state law that regulates insurance. This is not surprising.

Section 29 U.S.C. § 1132 itself contains no preemption language. Moreover, the express language of ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A), and ERISA's interpretive provision, 29 U.S.C. § 1144(d), negate any inference that § 1132 could, by implication, preempt a state law that regulates insurance. Sections 1132 and 1144 are both part of the same subchapter – subchapter 1 of Chapter 18, Title 29 of the United States Code. With § 1132 in mind, ERISA's savings clause reads as follows:

> . . . nothing in this subchapter [to include § 1132] shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . .

Similarly, with § 1132 and the McCarran-Ferguson Act in mind, ERISA's interpretive clause reads as follows:

> Nothing in this subchapter [to include § 1132] shall be construed to alter, amend, modify,

> invalidate, impair, or supercede [the McCarran-Ferguson Act].

IV. Instead of Applying the Preemption Test Required by This Court's *Kentucky Ass'n* Decision, the Ninth Circuit Used an Improper Preemption Analysis That Has Been Expressly Rejected by the Second and Third Circuits and Implicitly Rejected by This Court.

A. The Ninth Circuit Bypassed the *Kentucky Ass'n* Savings Clause Test to Find Implied Preemption Under § 1132.

In *Kentucky Ass'n of Health Plans, Inc. v. Miller*, ___ U.S. ___, 123 S.Ct. 1471 (2003), this Court held that a state law is saved from preemption by ERISA's savings clause if the state law satisfies two requirements:

> First, the state law must be specifically directed toward entities engaged in insurance. (Citing authority.) Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insureds.

Kentucky Ass'n, 123 S.Ct. at 1479. Although the Ninth Circuit acknowledged this two-pronged test, *Elliot*, 337 F.3d at 1142, the Ninth Circuit declined to follow it. Instead, the Ninth Circuit held that even if Montana's UTPA statutes satisfied the *Kentucky Ass'n* requirements, and were thereby saved from preemption by the savings

clause,[4] Montana's UTPA statutes would be preempted by § 1132: "Section 1132, as construed by *Rush Prudential,* thus preempts Elliot's claims." *Id.* at 1147. In reaching this conclusion, the Ninth Circuit relied on this Court's dicta in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), indicating that § 1132 would preempt duplicative or alternative state law remedies against an employer for ERISA-related violations. *Elliot*, 337 F.3d at 1146-47.

The Ninth Circuit's decision incorrectly ignored ERISA's savings and interpretive clauses and disregarded this Court's decision in *Kentucky Ass'n*. Despite the savings and interpretive clause language that expressly prohibits § 1132 from being construed to preempt state laws regulating insurance, the Ninth Circuit did precisely that. It essentially held that Congress would have included a remedy in § 1132 for unfair and deceptive claims practices if Congress had wanted to prohibit such conduct.

What the Ninth Circuit overlooked is that § 1132 does not provide a civil remedy for unfair and deceptive claims practices because Congress never intended for ERISA to regulate insurance. Instead, ERISA's savings clause expressly reserves to the states the power to regulate insurance under the McCarran-Ferguson Act. Thus, the absence of a remedy in § 1132 for an insurer's unfair and deceptive claims adjusting practices provides no basis for preempting Montana's UTPA statutes given that ERISA

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[4] The Ninth Circuit stated that it "might well find" that Montana's UTPA satisfied the *Kentucky Ass'n* preemption test. *Elliot*, 337 F.3d at 1146.

was never intended to regulate claims adjusting practices in the first place.

The Ninth Circuit's decision also renders this Court's *Kentucky Ass'n* decision superfluous. If § 1132 provides the exclusive remedy against employers and insurers alike, there is no need to determine whether a state law regulates insurance. If the Ninth Circuit is correct in concluding that § 1132 trumps both ERISA's savings clause and interpretive clause, then ERISA preemption turns only on whether the claimant seeks a remedy not provided by ERISA. That is why the Ninth Circuit leapfrogged over this Court's *Kentucky Ass'n* test and based its decision solely on § 1132. In doing so, however, the Ninth Circuit not only disregarded the analysis required by *Kentucky Ass'n*, but ignored this Court's precedent holding that ERISA does not preempt state laws regulating insurance or all state remedies that relate to ERISA plans. *See, e.g., Franchise Tax Board v. Constr. Laborers*, 463 U.S. 1, 25 (1983) (ERISA's savings clause "makes clear that Congress did not intend to preempt entirely every state cause of action relating to such plans."); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746 (1985) (Nothing in "the language, structure, or legislative history" of ERISA justifies a narrow reading of the savings clause or an interpretation that would nullify the savings clause.)

B. Both the Second Circuit and the Third Circuit Have Held That § 1132 Does Not and Cannot Preempt a State Law Saved from Preemption by ERISA's Savings Clause.

The Ninth Circuit's decision also conflicts with decisions from the Second Circuit and Third Circuit. In

Franklin H. Williams Ins. Trust v. Travelers Ins. Co., 50 F.3d 144, 151 (2nd Cir. 1995), for example, the Second Circuit rejected the argument that a state law saved from preemption under ERISA's savings clause could nonetheless be preempted by § 1132:

> We conclude that § 3214(c) [New York statute requiring interest on life insurance proceeds to be paid from the date of death] is saved from preemption under ERISA. Accordingly removal was improper. It also follows that the district court erred in holding that ERISA's civil enforcement provision, § 1132(a)(1)(B), preempts enforcement of the New York law, *see Williams,* 847 F.Supp. at 26-27, because such a result would be plausible only if the state law itself were also preempted. *It would be quixotic to rule that a claim under a statute that is saved from ERISA preemption, with the result that the claim may not be removed to federal court, may nonetheless be enforced only via ERISA provisions and remedies.* We note in this connection that in *Metropolitan Life*, after finding the challenged Massachusetts statute to be safe from preemption by § 1144(b)(2)(a), the Court affirmed a state court injunction mandating compliance with the state law. (Emphasis supplied.)

Similarly, in *Pas v. Travelers Ins. Co.*, 7 F.3d 349, 356 (3rd Cir. 1993), the Third Circuit rejected the argument that § 1132 can independently preempt a state law that regulates insurance:

> In *McClendon*, the Supreme Court stated that conflict preemption occurs when a state statute "purports to provide a remedy for the violation of a right expressly guaranteed by [a section of ERISA] and exclusively enforced by § 502(a) [of

> ERISA]." (Citing authority.) Section 17B: 30-12(d) purports to provide a proper plaintiff with a remedy for an insurance carrier's violations of an insured handicapped person's right not to be unfairly discriminated against in the terms and conditions of a health insurance policy. Travelers does not, and could not reasonably, contend that any provision of ERISA expressly guarantees this same right. Accordingly, we conclude that a necessary requirement for conflict preemption is missing here.

Although both the *Franklin H. Williams* case and the *Pas* case relied upon pre-*Kentucky Ass'n* tests to determine whether the state law at issue regulated insurance, both the Second and Third Circuits rejected the position now taken by the Ninth Circuit that § 1132 can itself preempt a state law saved from preemption under ERISA's savings clause. *See, also, Rosenbaum v. UNUM Life Ins. Co. of Am.*, ___ F.Supp.2d ___, 2003 WL 22078557 at *8 (E.D.Pa. Sept. 8, 2003) (" . . . Congress' intent was clear, it wanted all state laws which regulate insurance to be exempt from preemption under ERISA."); *Stone v. Disability Mgt. Serv. Inc.*, ___ F.Supp.2d ____, 2003 WL 22351755 at *10 (M.D.Pa. October 14, 2003) ("Apart from the requirement that the law needs to regulate insurance, Congress did not place any other requisites on the state laws that the clause saves from preemption.")

C. In *Rush*, This Court Strongly Indicated That it Would Not Accept Any Argument That § 1132 Limits or Preempts ERISA's Savings Clause.

To be sure, this Court has noted that Congress, in passing ERISA, intended to provide *employers* with a

predictable and uniform set of standards and liabilities to encourage them to provide benefits through ERISA plans. *Rush*, 536 U.S. at 379. As this Court recognized in *Rush*, where ERISA provides a remedy for an employer's wrongful discharge of an employee to avoid paying pension plan benefits, the ERISA remedy preempts any corresponding state law remedy. *Id.* Also in *Rush*, however, this Court was careful to state that although Congress intended for ERISA to impose uniform standards and liabilities upon employers, Congress did not extend that uniformity to insurers:

> Rush still argues for going beyond *Pilot Life*, making the preemption issue here one of degree, whether the state procedural imposition interferes unreasonably with Congress's intention to provide a uniform federal regime of "rights and obligations" under ERISA. However, "[s]uch disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life*, 471 U.S. at 747, 105 S.Ct. 2380. Although we have recognized a limited exception from the savings clause for alternative causes of action and alternative remedies in the sense described above, we have never indicated that there might be additional justifications for qualifying the clause's application. *Rush's arguments today convince us that further limits on insurance regulation preserved by ERISA are unlikely to deserve recognition.* (Emphasis supplied.)

Id. at 381. Thus, while Congress intended to apply a uniform set of ERISA's standards and liabilities to employers, that intent did not include insurers because Congress, through ERISA's savings clause, left insurance

regulation to the states as required by the McCarran-Ferguson Act.

This Court in *Rush* clearly recognized that while ERISA prevented states from imposing additional liabilities or remedies upon an employer, ERISA did not preclude a state from enforcing the laws it passed to regulate insurers. The Ninth Circuit overlooked this critical distinction. *Rush* provides no basis for the Ninth Circuit's holding that § 1132 can preempt a remedy provided by a state law saved from preemption by ERISA's savings clause.

V. Only the States, Through Statutes Like Montana's UTPA, Can Prohibit Unfair and Anticompetitive Claims Adjusting Practices.

Although ERISA did provide Ms. Elliot with a remedy for recovering her disability benefits, ERISA provided her no recourse for the injuries and damages she suffered when Fortis mistreated her in adjusting her claim. While she was totally disabled and critically ill, Fortis purported to quote language from the Crowley Law Firm policy that required Ms. Elliot to return to active work for at least one day before she would be eligible for benefits. No such language existed. Fortis could not have mistakenly "quoted" that language from the Crowley policy. Fortis was obviously trying to discourage Ms. Elliot from pursing her claim for disability benefits.

When that did not work, Fortis told Ms. Elliot that she was not entitled to benefits because she had been treated for cancer during the three months before she began work at the Crowley Law Firm. That also was not true. In fact, Fortis knew from the medical records it had

obtained that Ms. Elliot did not have cancer and was taking Tamoxifen only to reduce her chances of developing cancer in the future.

Fortis also knew that its pre-existing condition argument was a red herring. The Crowley law firm policy excluded coverage for pre-existing conditions for only one year. Ms. Elliot had been continuously insured for over one year when she applied for benefits. Fortis just ignored the one year time limit on asserting a pre-existing condition exclusion. Finally, Fortis made Ms. Elliot file suit and litigate for nearly eleven months before the District Court ruled that she was entitled to disability benefits. Fortis tried to use litigation to discourage Ms. Elliot.

At stake in the Ninth Circuit's decision is whether Ms. Elliot can hold Fortis accountable under Montana law for the unfair and deceptive practices it used to deny her claim. If the Ninth Circuit's decision stands, then Montana's UTPA is toothless when applied to employer-sponsored group life, health, or disability insurers. ERISA's group insurers will be free to misrepresent policy provisions, to ignore and misconstrue medical records, and to delay payment knowing that, in the end, they will only be required to pay those benefits they should have paid in the first place.

The Ninth Circuit's decision has left millions of ERISA plan employees and their beneficiaries vulnerable to unfair and deceptive trade practices. For every person like Ms. Elliot who persists in recovering the benefits that are rightfully hers, many more will lack the determination or resources to obtain representation or to endure lengthy litigation. Those victimized by unfair and deceptive trade practices must often turn to state welfare benefits for

assistance. That is why states like Montana have a compelling interest in discouraging insurers from employing unfair and deceptive trade practices and for penalizing those who do. Ironically, the Ninth Circuit's decision, far from furthering ERISA's purpose to protect the rights of employees participating in welfare benefit plans, actually eliminates their right, *protected only by state law*, to prompt and fair payment of insurance benefits. Economic necessity will force other insurers to adopt unfair and deceptive claims adjusting practices just to stay competitive. This is the real legacy of the Ninth Circuit's decision.

CONCLUSION

Ms. Elliot respectfully requests that this Court grant her petition for certiorari to review the Ninth Circuit's decision in this case. Had the Ninth Circuit applied this Court's *Kentucky Ass'n* test, her UTPA claims would not have been preempted. If the Ninth Circuit's decision stands, then no state in the Ninth Circuit will be able to prohibit unfair and deceptive claims adjusting practices.

DATED this 30th day of October, 2003.

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FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STEPHANIE ELLIOT, *Plaintiff-Appellant-Cross-Appellee,* v. FORTIS BENEFITS INSURANCE COMPANY, *Defendant-Appellee-Cross-Appellant.*	Nos. 02-35080 02-35133 D.C. No. CV 01-11-RFC OPINION

Appeal from the United States District Court
for the District of Montana
Richard F. Cebull, District Judge, Presiding

Argued and Submitted
May 9, 2003 – Seattle, Washington

Filed August 1, 2003

Before: Richard D. Cudahy,* Diarmuid F. O'Scannlain and Ronald M. Gould, Circuit Judges.

Opinion by Judge Cudahy

COUNSEL

Donald L. Harris, Cozzens, Warren & Harris, PLLP, Billings, Montana, for the plaintiff-appellant.

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* The Honorable Richard D. Cudahy, Senior United States Circuit Judge for the Seventh Circuit, sitting by designation.

Robert L. Sterup, Peteresen, Jones, Hingle & Sterup, PLLC, Billings, Montana, for the defendant-appellee.

OPINION

CUDAHY, Circuit Judge:

Stephanie Elliot, a terminally ill former paralegal, sued Fortis Benefits Insurance Company, claiming benefits and other damages under a long-term disability insurance policy she had through her employer. She prevailed on her Employee Retirement Income Security Act (ERISA) claims, and recovered policy benefits and attorney's fees and costs, but lost on Fortis's motion for judgment on the pleadings on her state law claims, under which she sought non-ERISA compensatory and punitive damages. Although recent case law requires us to reconsider whether ERISA preempts such state law claims, we affirm the judgment of the district court.

I.

Stephanie Elliot was first diagnosed with cancer in 1995. She successfully underwent a right modified mastectomy, chemotherapy, stem-cell transplant and other treatment, and her breast cancer was found to be in complete remission. As of July 9, 1997, her oncologists noted that she had "no measurable disease," and regular examinations deemed her cancer-free as late as September 16, 1999. Nonetheless, to lessen the risk that she would

develop cancer in the future, Elliot was placed on Tamoxifen[1] therapy beginning in July 1996. According to her doctor, the Tamoxifen was not prescribed for the treatment of any active cancer or other disease.

Elliot started working as a paralegal at the Crowley Law Firm on September 27, 1999. As part of her compensation, she was enrolled in Crowley's long-term disability insurance policy with Fortis Benefits Insurance Company. This coverage was effective as of her first day of work. This policy, however, contained restrictions on coverage for pre-existing conditions, which were defined as follows:

> A "pre-existing condition" means an injury, sickness, or pregnancy or any related injury, sickness, or pregnancy for which you:
>
> - consulted with or received advice from a licensed medical or dental practitioner; or
>
> - received medical or dental care, treatment, or services, including taking drugs, medicine, insulin, or similar substances
>
> during the 3 months that end on the day before you became insured under the long term disability insurance policy.

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[1] Tamoxifen is an antiestrogen drug that has been shown to reduce the risk of recurrence of cancer and the risk of developing new cancers in breast cancer survivors. *See generally* Nat'l Cancer Inst., *Tamoxifen: Questions and Answers, at* http://cis.nci.nih.gov/fact/7_16.htm (last visited July 24, 2003).

The policy excludes benefits "for any disability caused by a pre-existing condition" until three consecutive months without treatment have passed or the beneficiary has been continuously insured under the policy for twelve consecutive months.

The first sign that Elliot's health was deteriorating came in December 1999, when her doctor noted elevated levels of Cancer Antigen 27.29, an early portent of cancer. Although her Cancer Antigen 27.29 levels subsequently declined, she suffered from growing headaches and pain in Summer 2000. On August 19, 2000, Elliot was diagnosed with brain and bone cancer. She was taken off Tamoxifen and did not return to work. At the time of this appeal, she was totally disabled and terminally ill.

For the first three months of her disability, Elliot was paid full salary under Crowley's short-term disability policy. Elliot then applied to Fortis for long-term disability benefits.

On October 30, 2000, Fortis sent Elliot a letter explaining the pre-existing condition limitation of her policy. The letter, however, in excerpting the policy provision dealing with pre-existing conditions, recited a requirement, not contained in the actual policy, that insureds be "at active work for a full day following" the three consecutive months of nontreatment or twelve consecutive months of coverage required under the policy. According to the new language, it appeared that Elliot would not qualify for coverage unless she returned to active work. The letter explained that Fortis would be conducting "a routine pre-existing review" because Elliot's date of disability, August 19, was within twelve months of the start of her coverage, September 27 of the preceeding year.

After a review of Elliot's medical history, Fortis denied disability benefits. Fortis reasoned that because Elliot was taking Tamoxifen and undergoing periodic checkups, her earlier breast cancer constituted a pre-existing condition. Because Elliot had a pre-existing condition, she was covered only if she could show three consecutive months of nontreatment or twelve consecutive months of coverage. Fortis found that she had seen doctors and had prescriptions dispensed regularly, with no three-month gap, and that her disability began within twelve months of the start of her coverage. To reach these conclusions, Fortis relied in part on the opinion of Dr. Patrick Cobb, Elliot's oncologist, who reported to Fortis that Elliot's current cancer was a metastasis from her earlier breast cancer and that Tamoxifen was prescribed to prevent the recurrence of breast cancer and its metastasis.

Elliot filed suit in the District of Montana against Fortis, making two claims for relief. First, Elliot sought policy benefits under ERISA. Second, she asserted violations of Montana's Unfair Trade Practices Act (UTPA),[2]

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[2] Elliot alleges that Fortis violated three subsections of the UTPA:

Mont. Code Ann. § 33-18-201 Unfair claim settlement practices prohibited.

No person may . . . do any of the following:

(1) misrepresent pertinent facts or insurance policy provisions relating to coverages at issue;

. . .

(4) refuse to pay claims without conducting a reasonable investigation based upon all available information;

. . .

(Continued on following page)

Mont. Code Ann. § 33-18-201, and sought non-ERISA compensatory and punitive damages. She prevailed on the first count, and that is not before us. On the state law claim, the district court granted Fortis's motion for judgment on the pleadings, Fed. R. Civ. P. 12(c), concluding that the state law claim is preempted by ERISA. Elliot appeals this ruling.

II.

We review de novo a Fed. R. Civ. P. 12(c) judgment on the pleadings. *McGann v. Ernst & Young,* 102 F.3d 390, 392 (9th Cir. 1996). ERISA preemption is a question of law, which we also review de novo. *Waks v. Empire Blue Cross/Blue Shield,* 263 F.3d 872, 874 (9th Cir. 2001).

The district court based its finding of preemption on two separate ERISA provisions. First, the district court held that the express preemption of ERISA § 514, 29 U.S.C. § 1144, which contains both a preemption and a saving clause, defeated Elliot's state law claim. Second, the district court noted that even if it were to find the substantive provisions of the UTPA not preempted, ERISA § 502(a), 29 U.S.C. § 1132(a), would preempt the enforcement provision of the UTPA which allows her to enforce the state law rights. We consider in some detail both lines of analysis.

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(6) neglect to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

. . .

A.

We begin by noting a recent change in the law involving § 1144. Section 1144(a) expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" in favor of federal regulation under ERISA. However, § 1144(b)(2)(A) saves from preemption "any law of any State which regulates insurance, banking, or securities." The parties agree that Montana's UTPA, as applied here against Fortis, would fall under § 1144(a). How do we determine whether the UTPA is included in the class of laws regulating insurance that are saved by § 1144(b)(2)(A) from ERISA preemption?

Until April of the current year, courts determining the reach of the ERISA saving clause (including the district court in this case) used a two-step test set forth in *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 740 (1985). The *Metropolitan Life* test instructed courts to ask first whether, from a "common-sense view," the state law regulates insurance. The second step was to determine whether the state law regulates "the business of insurance." This is the telling phrase that was borrowed from the McCarran-Ferguson Act.[3] *See* 15 U.S.C. § 1011 ("Congress hereby declares that the continued regulation and taxation by the several States of *the business of insurance* is in the public interest, and that silence on the part of the

[3] The McCarran-Ferguson Act, Pub. L. No. 79-15, 59 Stat. 33 (1945), was an effort by Congress to protect states' primary regulatory role over the insurance industry. It was in part a reaction to *United States v. South-Eastern Underwriters Ass'n,* 322 U.S. 533 (1944), which held that insurance could constitute interstate commerce subject to federal jurisdiction.

Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.") (emphasis added). In order to determine whether a given state law regulated "the business of insurance," courts were to consider three elements laid out in *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 129 (1982) (emphasis omitted): "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."

But in *Kentucky Ass'n of Health Plans, Inc. v. Miller,* 123 S. Ct. 1471, 1479 (2003), the Supreme Court "ma[de] a clean break from the McCarran-Ferguson factors" for determining the reach of the ERISA saving clause. "[F]or a state law to be deemed a 'law . . . which regulates insurance' under § 1144(b)(2)(A), it must [now] satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. . . . Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured." *Id.* (citations omitted). Thus, to determine the reach of § 1144 preemption, we must ask whether the UTPA is "specifically directed toward entities engaged in insurance" and whether it "substantially affect[s] the risk pooling arrangement between the insurer and the insured." As is immediately apparent, both these questions are actually remnants of the *Metropolitan Life* test, which asked as part of its analysis "whether the practice is limited to entities within the insurance industry," and "whether the practice has the effect of transferring or spreading a policyholder's risk."

B.

Because of the similarities between the *Metropolitan Life* and *Kentucky Association* approaches, it is well worth considering the substantial body of case law applying the older test. Of these cases, perhaps the most relevant Supreme Court precedent is *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

In that case, a policyholder had sued Pilot Life for failure to pay benefits under a permanent disability policy that he had obtained through his employment. The Supreme Court held that a Mississippi state cause of action alternatively called "tortious breach of contract" and "the law of bad faith" was preempted by ERISA. *Id.* at 48, 57. The Court held that the Mississippi law fell under the ERISA preemption clause, but was not saved by the ERISA saving clause, because it failed the *Metropolitan Life* test. Of this analysis, two findings made by the *Pilot Life* court remain relevant. The Court first found that Mississippi's bad faith law was not directed specifically at insurance companies because while "the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law." *Pilot Life,* 481 U.S. at 50. "Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law." *Id.* Second, the Court found that the "common law of bad faith does not effect a spreading of policyholder risk." *Id.*

In addition to this straightforward application of the *Metropolitan Life* test, *Pilot Life* also introduced the concept of preemption by ERISA § 502(a), 29 U.S.C. § 1132(a). Accepting an argument made by the Solicitor

General, the *Pilot Life* court stated that § 1132 (the private enforcement provision),[4] is "the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life,* 481 U.S. at 52. The Court compared the broad preemption of the ERISA enforcement provision to that of the Labor-Management Relations Act of 1947, *id.* at 51-54, and concluded that, the *Metropolitan Life* test aside, state laws such as the Mississippi bad faith law may be preempted simply because they provide individuals with a private cause of action that is not available to them under ERISA.

We have previously followed *Pilot Life.* In *Greany v. Western Farm Bureau Life Ins. Co.,* 973 F.2d 812, 819 (9th Cir. 1992), we applied the § 1132 preemption of *Pilot Life* specifically to the Montana UTPA, holding that the UTPA "do[es] not 'regulate[ ] insurance' . . . but [is a] civil enforcement provision[ ]" preempted by ERISA. Other Ninth Circuit cases have also found similar state laws preempted, seemingly relying on § 1132 preemption as well as on § 1144 preemption and its *Metropolitan Life* test to dismiss state law insurance claims. *See Bast v. Prudential Ins. Co. of Am.,* 150 F.3d 1003, 1008 (9th Cir. 1998) (noting that "we have held that insurance bad faith claims are preempted by ERISA"); *Tingey v. Pixley-Richards West, Inc.,* 953 F.2d 1124, 1133 (9th Cir. 1992) (holding that an Arizona tort for breach of duty of good faith and fair

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[4] 29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought –

(1) by a participant or beneficiary. . . .

dealing was preempted by ERISA); *Kanne v. Conn. Gen. Life Ins. Co.*, 867 F.2d 489, 493-94 (9th Cir. 1988) (holding that a California law prohibiting unfair insurance practices was preempted by 29 U.S.C. § 1132).

It would be relatively straightforward to apply the reasoning of *Pilot Life* and *Greany* to the present case. For one, we could look to § 1144 and the *Kentucky Association* test: Is the UTPA "specifically directed toward entities engaged in insurance" and does it "substantially affect the risk pooling arrangement between the insurer and the insured?" According to *Pilot Life,* the fact that Montana recognizes a tort of bad faith in non-insurance contexts, *see Story v. City of Bozeman,* 791 P.2d 767, 776 (Mont. 1990) ("The [bad faith] tort remedy may also be available in contracts . . . not otherwise controlled by specific statutory provisions."); Fortis Br. at 30-31, may defeat the fact that the UTPA is, superficially at least, specifically directed at insurance, *see* Mont. Code Ann. § 33-18-101 ("The purpose of this chapter is to regulate trade practices in the business of insurance."). However, because the Montana law is statutory, unlike the Mississippi common law, our conclusion may be that the provision *is,* by its own terms, "specifically directed" at insurance companies. Second, the *Pilot Life* court remarked that the Mississippi bad faith law did not effect a spreading of risk. This conclusion would probably apply equally to the Montana law, resulting in the UTPA's failing the second prong of the *Kentucky Association* test and not being saved by the ERISA saving clause.

Alternatively, we could look to *Pilot Life's* § 1132 preemption. Under that provision of *Pilot Life,* the UTPA could be preempted because UTPA's civil enforcement provision, Mont. Code Ann. § 33-18-242, violates the

implicit requirement that § 1132 is "the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life,* 481 U.S. at 52.

In summary, there are three aspects of *Pilot Life* that still indicate preemption here: 1) claims processing laws are not "specifically directed" at insurance if bad faith claims can be made in other settings, 2) claims processing laws do not affect the risk-pooling arrangement and 3) all state private causes of action for claim processing are preempted by ERISA's § 1132 enforcement provision. If any one of these *Pilot Life* conclusions is supported by subsequent case law, we must rely on the holding of *Greany* and affirm the district court. But we find that subsequent case law puts the validity of all three of these *Pilot Life* conclusions into some doubt, making the present case considerably more difficult.

C.

The principal case challenging some of *Pilot Life's* conclusions is *UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358 (1999). In *UNUM,* the Supreme Court considered whether a California law that validated claims filed after a filing deadline, provided that the delay did not cause prejudice to the insurance company, a so-called "notice-prejudice" rule, was preempted by ERISA. A unanimous Supreme Court concluded, upholding the Ninth Circuit, that the notice-prejudice rule is saved by the ERISA saving clause. *Id.* at 373. In doing so, *UNUM* cast doubt on all three of the *Pilot Life* principles that are potentially controlling here.

First, *UNUM* took a much more generous approach than did *Pilot Life* in analyzing whether a law was specifically directed at insurance. The Court found that the California law "by its very terms, 'is directed specifically at the insurance industry and is applicable only to insurance contracts,'" and rejected UNUM's argument that the general disposition of California law against forfeiture, including cases applying something akin to a notice-prejudice rule in non-insurance contexts, somehow defeated the circumstance that the California notice-prejudice rule itself was literally directed at insurance companies. *UNUM,* 526 U.S. at 368-73. Applying this view, the UTPA probably meets the first requirement of the *Kentucky Association* test, since the UTPA "by its very terms" is directed at insurance, and contains provisions applicable only to insurance companies. *See, e.g.,* Mont. Code Ann. § 33-18-101 ("The purpose of this chapter is to regulate trade practices in the business of insurance. . . ."); *id.* § 33-18-201 (forbidding certain claim settlement procedures).

UNUM also calls into question *Pilot Life's* conclusion that a claim processing law does not affect risk allocation. Although this was not a question the *UNUM* court reached, the *UNUM* court noted without disapproval the federal government's amicus brief argument that "[i]nsofar as the notice-prejudice rule shifts the risk of late notice and stale evidence from the insured to the insurance company in some instances, it has the effect of raising premiums and spreading risk among policyholders." *UNUM,* 526 U.S. at 374. The *Kentucky Association* court confirmed that the notice-prejudice rule "certainly qualifies as [having] a substantial effect on the risk pooling arrangement between the insurer and insured." *Kentucky*

Association, 123 S. Ct. at 1477 n.3. *UNUM* and *Kentucky Association* thus leave open the possibility that risk spreading might be found in a much wider variety of statutes than *Pilot Life* suggested. Under these potentially broader concepts of risk-pooling, it is entirely plausible to find that the UTPA allocates risk "by obligating insurers to make advance payments before the duty to indemnify under the policy is triggered" and "by requiring insurers to pay excess judgments against their insureds" in the case of a UTPA violation. *See* Elliot's Opening Br. at 22 (citing *Ridley v. Guaranty Nat'l Ins. Co.,* 951 P.2d 987, 992 (Mont. 1997), which held that, under the UTPA, insurance companies must make payments as soon as liability becomes reasonably clear). *But see Howard v. Coventry Health Care, of Iowa, Inc.,* 293 F.3d 442, 447 (8th Cir. 2002) (reiterating, post-*UNUM,* that bad faith laws do not spread risk).

Most significantly, perhaps, *UNUM* questioned the preemptive force of ERISA's civil enforcement provision, 29 U.S.C. § 1132(a). UNUM Life Insurance had argued that § 1132 barred any state cause of action involving claim processing, a broad, literal reading of *Pilot Life.* The *UNUM* court found this argument irrelevant because the *UNUM* plaintiff had not brought the action based on a state cause of action; instead, the California statute became relevant only when cited to meet the insurer's defense that the plaintiff's claim was untimely. However, the Court specifically noted in its footnote seven the Solicitor General's argument that the ERISA saving cause, 29 U.S.C. § 1144(b)(2)(A), also saves state causes of action that regulate insurance, i.e., that as long as the state law being enforced is saved as a law regulating insurance under § 1144(b)(2)(A), its enforcement provision is also

saved from § 1132 preemption. *See UNUM,* 526 U.S. at 376 n. 7. With this footnote (bringing potential § 1132 preemption within the preclusive coverage of § 1144(b)(2)(A)), *UNUM* appeared to narrow significantly *Pilot Life's* language on § 1132's independent preemptive power.

D.

Thus, none of *Pilot Life's* three principles noted above escaped unquestioned by *UNUM.* Following the latter case, we might well find the UTPA to be specifically directed toward entities engaged in insurance, and it is certainly possible that we would find the UTPA to substantially affect the risk pooling arrangement between the insurer and the insured. *See, e.g., Rosenbaum v. Unum Life Ins. Co. of Am.*, No. Civil 01-6758, 2002 WL 1769899 (E.D. Pa. July 29, 2002) (finding, under a post-*UNUM* application of the *Metropolitan Life* test, a state bad faith law not to be preempted by ERISA). As things stand, however, we do not have to reach these issues because *Pilot Life's* theory of § 1132 preemption has been narrowly but sufficiently re-affirmed by the Supreme Court subsequent to *UNUM's* footnote seven and the questions it might raise.

The level of preemptive force of § 1132 was clarified in *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355 (2002). In considering an Illinois law that provided a right to independent medical review of certain denials of benefits, the Supreme Court concluded that, while the independent review may resemble a separate arbitration proceeding going beyond ERISA's enforcement provisions, the independent review was not precluded by the preemption principle of *Pilot Life. Rush Prudential,* 536 U.S. at 380-83. In reaching

this conclusion, *Rush Prudential* removed much of the precedential force of this aspect of *Pilot Life,* calling *Pilot Life's* discussion of preemption by § 1132 "dictum." *Id.* at 377. The *Rush Prudential* court explained the genesis of *Pilot Life's* invocation of § 1132, and recharacterized *Pilot Life's* holding to mean only that "ERISA would not tolerate a diversity action seeking monetary damages for breach generally and for consequential emotional distress, neither of which Congress had authorized in § 1132(a)." *Id.* at 378. The *Rush Prudential* court noted that only once since *Pilot Life,* in *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133 (1990), had it re-affirmed the *Pilot Life* conclusion that § 1132 might preempt a state remedy. *Rush Prudential,* 536 U.S. at 379. According to the Court in *Rush Prudential,* the problem in *Ingersoll-Rand* was that a "state law duplicated the elements of a claim available under ERISA" while converting the remedy "from an equitable one under § 1132(a)(3) . . . into a legal one for money damages." *Id.* The Court explained, thus narrowly re-affirming *Pilot Life,* that preemption by § 1132 constitutes "a limited exception from the saving clause" for causes of action and remedies alternative to ERISA. *Id.* at 381. While the Court described this exception to the saving clause as quite limited, the exception does include state causes of action that would "significantly expand[ ] the potential scope of ultimate liability imposed upon employers" by ERISA, and such claims are preempted. *Id.* at 379. In other words, § 1132's preemptive effect depends on the nature of the state remedy, including the availability of non-ERISA compensatory and punitive damages. Thus, the availability of such non-ERISA damages is a strong indicator that a state cause of action may be preempted.

Applying *Rush Prudential* as controlling here would dictate preemption. But there are two possible distinctions between *Rush Prudential* and the instant case. First, Montana's UTPA arguably does not fall squarely under *Rush Prudential's* characterization of *Ingersoll-Rand*. According to *Rush Prudential*, the problem with the state law cause of action in *Ingersoll-Rand* was that it "duplicated the elements of a claim available under ERISA, [but] converted the remedy." *Rush Prudential*, 536 U.S. at 379. In contrast, here the UTPA may instead provide rights in addition to those provided by ERISA by, for example "obligating insurers to make advance payments before the duty to indemnify under the policy is triggered." *Ridley*, 951 P.2d at 992. We do not, however, read *Rush Prudential's* re-affirmation of *Pilot Life* as limited narrowly to the precise circumstances of *Ingersoll-Rand*. *See Rush Prudential*, 536 U.S. at 380 (citing *Pilot Life*, *Ingersoll-Rand* and *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), as examples of the types of cases invoking § 1132 preemption). The instant action, which seeks non-ERISA damages for what are essentially claim processing causes of action, clearly falls under the § 1132 preemption exemplified by *Pilot Life*.[5] Also, Elliot asks us to distinguish *Rush*

[5] There is one related question we do not reach. As argued by Elliot, *Ridley* requires Montana insurers to make advance payments to policyholders when liability becomes reasonably clear. It is possible that the UTPA will trigger responsibility for these payments before coverage is confirmed under ERISA. If an insured in these circumstances brought an action against her insurance company, and sought no remedies in addition to those that ERISA might eventually provide, it is not entirely clear under *Pilot Life*, *Rush Prudential* and our holding today that her lawsuit would be preempted by ERISA. This circumstance, we believe, may be distinguished from the situation here, where an insured is seeking, after the underlying ERISA claims have been

(Continued on following page)

Prudential on the ground that its main concern was the potential liability imposed upon *employers,* whereas the present action is against an insurance company rather than an employer. While this may be true, the nature of the defendant alone does not suffice to save a claim which conflicts with ERISA's enforcement scheme. *Cf. Bast,* 150 F.3d at 1008 (noting that for questions of ERISA preemption, "[t]he key issue is whether the parties' relationships are ERISA-governed relationships" and not the precise roles played by the parties).

Section 1132, as construed by *Rush Prudential,* thus preempts Elliot's claims. Unlike the notice-prejudice rule involved in *UNUM,* which only provided a "relevant rule of decision" for a suit brought under § 1132, *UNUM,* 526 U.S. at 377, Elliot's claim relies in the first instance on Montana's UTPA's civil enforcement provision, Mont. Code Ann. § 33-18-242. Unlike the *not* preempted independent review mechanism of *Rush Prudential,* Mont. Code Ann. § 33-18-242 provides damages above and beyond those provided in ERISA, including punitive damages. Because the present case "involve[s] the sort of additional claim or remedy exemplified in *Pilot Life," Rush Prudential,* 536 U.S. at 380, it falls within § 1132 preemption. *Accord Fink v. Dakotacare,* 324 F.3d 685, 689 (8th Cir. 2003) (applying *Rush Prudential* and declaring a state claims processing law preempted); *Conover v. Aetna U.S. Health Care, Inc.,* 320 F.3d 1076, 1079-80 (10th Cir. 2003) (same); *Caffey v. UNUM Life Ins. Co.,* 302 F.3d 576, 582 (6th Cir. 2002)

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resolved, non-ERISA damages for failure to make advance payments under the UTPA.

(same); *Emil v. UNUM Life Ins. Co. of Am.*, No. 3:CV02-2019, 2003 WL 256781 (M.D. Pa. Feb. 5, 2003) (same).

III.

We review a district court's decision to award attorney's fees under ERISA for abuse of discretion. *Williams v. Caterpillar, Inc.*, 944 F.2d 658, 668 (9th Cir. 1991). ERISA provides that a "court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C. § 1132(g)(1). In order to determine the appropriateness of an award of fees, the court should generally consider five factors: "(1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing party to satisfy an award of fees; (3) whether an award of fees ... would deter others from acting under similar circumstances; (4) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions." *Hummell v. S.E. Rykoff & Co.*, 634 F.2d 446, 453 (9th Cir. 1980); *see also Landwehr v. DuPree*, 72 F.3d 726, 739 n.5 (9th Cir. 1995).

Fortis argues that much of the fees Elliot incurred were not compensable under § 1132(g)(1) because those fees were incurred pursuing non-ERISA claims. However, we have held that the *Hummell* factors should be "liberally construed in favor of protecting participants in employee benefits plans." *McElwaine v. U.S. West, Inc.*, 176 F.3d 1167, 1172 (9th Cir. 1999). Successful plaintiffs in ERISA suits should ordinarily recover fees unless special circumstances would render such an award unjust. *Id.* The district court's grant of fees was well within its discretion.

IV.

For the foregoing reasons, we AFFIRM the decision of the district court.

UNITED STATES DISTRICT COURT
DISTRICT OF MONTANA
BILLINGS DIVISION

STEPHANIE ELLIOT, Plaintiff(s), -vs- FORTIS BENEFITS INSURANCE CO., Defendant(s).	))))))))	JUDGMENT CV-01-11-BLG-RFC (Filed Nov. 8, 2001)

____ **July Verdict**. This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

xxx **Decision by Court**. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED:

Judgment is entered in accordance with the attached Order.

November 8, 2001

Patrick Duffy
CLERK

Reyna M. Weies
(By) DEPUTY CLERK

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
BILLINGS DIVISION

STEPHANIE ELLIOT, Plaintiff, vs. FORTIS BENEFITS INSURANCE COMPANY, Defendants.	Cause No. CV 01-11-BLG-RFC ORDER * * * (Filed Nov. 8, 2001)

On Wednesday, October 2, 2001, the Court heard oral argument on the pending pretrial motions. Donald Harris represented plaintiff; Robert Sterup appeared on behalf of the defendant.

Background

This case was filed by plaintiff Stephanie Elliot under the Montana Unfair Claims Settlement Practices Act seeking benefits under a long-term group disability policy, compensatory damages caused by Fortis's alleged wrongful refusal to pay disability benefits, and punitive damages.

Stephanie Elliot was originally diagnosed with breast cancer in December of 1995. She underwent a right modified mastectomy, chemotherapy, stem-cell transplant, and other treatment for the disease. The treatment was successful in that Ms. Elliot was in complete remission. Elliot's medical records maintained by her oncologists in Billings, Montana, reflect that she had "no measurable

disease" as of July 9, 1997. Elliot was placed on the medication Tamoxifen in July of 1996 and remained on Tamoxifen up through August of 2000. Tamoxifen was prescribed to lessen the chances that Elliot would develop cancer in the future.

Elliot became employed at the Crowley Law Firm and insured under that firm's long-term group disability policy, issued by Fortis, with an effective date of September 27, 1999. Elliot's last day of work was August 18, 2000. The next day she was diagnosed with metastatic breast cancer that spread to the brain and bones. Under its own short-term disability policy, the Crowley Law Firm paid Ms. Elliot her full salary through November 20, 2000.

After purportedly conducting a review of plaintiff's medical history, Fortis concluded that Elliot's condition was "pre-existing" and consequently, not covered under the policy.

Fortis maintains that Elliot's state law claims are preempted by ERISA and it is entitled to summary judgment because Fortis did not abuse its discretion in determining that Elliot's disabling condition was caused by a pre-existing condition.

> Defendant's Motion for Judgment on the Pleadings and to Strike Jury Demand and;
>
> Plaintiff's Rule 12(c) Motion for Judgment on the Pleadings on Fortis's Fifth Defense

The motions for judgment on the pleadings present the issue of whether plaintiff's state law claims are preempted by ERISA or whether they are exempt from preemption under ERISA's savings clause.

Plaintiff's state law claims arise under the Montana Unfair Claims Settlement Practices Act, Mont. Code Ann. § 33-18-201, subparagraphs 1, 4, and 6, which prohibits insurance companies from "(1) misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;" "(4) refusing to pay claims without conducting a reasonable investigation based upon all available information;" and "(6) neglecting to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear." Mont. Code Ann. § 33-18-242 affords the insured an independent cause of action for actual and punitive damages caused by the insurer's violation of section 33-18-201. It also allows the insured to bring breach of contract and fraud claims against the insurer. It is these claims Fortis contends are preempted by ERISA.

With good reason, the parties agree that plaintiff's state law claims "relate to" an ERISA plan and thus, fall within the broad sweep of the preemption clause. 29 U.S.C. § 1144(a). However, ERISA also contains a savings clause which exempts from preemption "any law of any state which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). In determining whether a state law "regulates insurance" and thus escapes preemption, this Court must first ask whether, from a common-sense view, the contested law regulates insurance. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740 (1985).

As reflected in its general provisions, the sole purpose of the Act is to regulate insurance.

> The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in Public Law 79-15 (the McCarran-Ferguson Act,

> 15 U.S.C. 1011 through 1015), which was approved March 9, 1945, by defining or providing for determination of all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

(General Provisions, Unfair Trade Practices Act (UTPA), Mont. Code Ann. § 33-18-101). One of the statutes at issue, Mont. Code Ann. § 33-18-201, is entitled "Insurer's Relations with Insured and Claimant" "unfair claim settlement practices prohibited." The other, Section 33-18-242, only allows actions against "an insurer." Because the contested laws are specifically directed toward the insurance industry, there is no question that from a common sense view, they regulate insurance.

The Court must next consider whether the state law regulates the "business of insurance," as that phrase is used in the McCarran-Ferguson Act, 15 U.S.C. Section 1011, et seq. *UNUM v. Ward*, 526 U.S. 358, 373 (1999). The three McCarran-Ferguson factors are considerations to be weighed in determining whether the state law regulates the business of insurance. *Id.* None of the factors "'is necessarily determinative in itself.'" *Id.* quoting *Union Labor Life Ins., Co. v. Pireno*, 458 U.S. 119, 129 (1982).

The first McCarran-Ferguson factor asks whether the state law at issue has the effect of transferring or spreading a policy holder's risk. Unlike the mandated benefits laws in *Metropolitan Life*, the relevant portions of the Unfair Claims Settlement Practices Act do not transfer or spread policy holders' risk. *See UNUM*, 526 U.S. at 374; *Metropolitan Life*, 471 U.S. at 743. Instead, they set forth conduct which the Montana legislature has deemed to

constitute unfair business practices and afford the insured a cause of action for damages against its insurer based upon those practices.

The second factor requires determining whether the state law at issue is "an integral part of the policy relationship between the insurer and the insured." *Metropolitan Life*, 471 U.S. at 743. Because the sections of UTPA at issue do not mandate benefits or regulate the terms of insurance contracts they are not an integral part of the policy relationship between the insurer and the insured. *UNUM*, 526 U.S. at 374-375.

The third McCarran-Ferguson factor asks whether the rule is limited to entities within the insurance industry. Mont. Code Ann. §§ 33-18-201 and 33-18-242 are, in fact, limited to the insurance industry.

Because only one of the McCarran-Ferguson factors weighs in favor of determining that the state laws at issue regulate the business of insurance, and because the Ninth Circuit has already found that the "Montana Unfair Claims Settlement Practices statutes do not 'regulate insurance' as discussed in [the savings clause], but are civil enforcement provisions" and thus preempted, *Greany v. Western Farm Bureau Life Insurance Co.*, 973 F.2d 812, 819 (9th Cir. 1992), this Court is likewise compelled to conclude that Mont. Code Ann. § 33-18-201(1), (4) and (6) and Mont. Code Ann. § 33-18-242 are preempted and do not fall within the ambit of ERISA's savings clause.

Moreover, even if this Court were to determine that the "substantive" provisions of the UTPA, Mont. Code Ann. § 33-18-201(1), (4) and (6), are not preempted, the Court would still be forced to conclude that plaintiff's state law claims for benefits and damages brought under Mont.

Code Ann. § 33-18-242 are preempted by ERISA's civil enforcement provision, 29 U.S.C. § 1132(a). *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). As the *Pilot Life* Court noted:

> [T]he detailed provisions of 29 U.S.C. § 1132(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. The six carefully integrated civil enforcement provisions found in 1132(a) provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly. [citation omitted]
>
> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive. This conclusion is fully confirmed by the legislative history of the civil enforcement provision. *Id.*

The *UNUM* Court recognized the practical effect of "saving" a state substantive law that regulates insurance noting, that while the plaintiff sued pursuant to 29 U.S.C. § 1132(a)(1)(B) for benefits due under an ERISA plan, a California insurance law saved from ERISA preemption supplied the relevant rule of decision for the case. *UNUM*,

526 at 376-377. Were the Court to reach a similar decision in this case, plaintiff's cause of action would arise under 29 U.S.C. § 1132(a)(1)(B), not Mont. Code Ann. § 33-18-242, and the rule of decision for the case would be supplied by Mont. Code Ann. § 33-18-201. However, because the Court has already determined that both Mont. Code Ann. § 33-18-201 and 33-18-242 are preempted, the Court is not faced with apply [sic] the law in such a fashion.

As a result of the preemption, the Court will construe plaintiff's action as one under 29 U.S.C. § 1132(a)(1)(B) to recover benefits due to her under the terms of the Fortis plan.

Fortis's Motion for Summary Judgment on the ERISA Claim

Fortis contends it is entitled to summary judgment on the ERISA claim because the plan administrator did not abuse its discretion in determining plaintiff is not entitled to coverage.

When an ERISA plan confers discretionary authority on a plan administrator to construe the terms of the plan and to determine benefit eligibility, this Court reviews the administrator's decision under the abuse of discretion standard. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *McDaniel v. Chevron Corp.*, 203 F.3d 1099, 1107 (9th Cir. 2000). The Fortis policy at issue provides:

> We have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by us are conclusive and binding on all parties.

The above-quoted language limits this Court's review to determining whether Fortis abused its discretion.

While this list is not exclusive, plan administrators abuse their discretion when they (1) render decisions without any explanation, (2) construe provisions of the plan in a way that conflicts with the plain language of the plan, (3) fail to develop facts necessary to make their determination, (4) make an error of law, or (5) operate under a conflict of interest. *Schikore v. Bankamerica Supplemental Retirement Plan*, 2001 WL 1222395 (9th Cir. 2001)

Under ERISA, interpretation of an insurance contract is governed by a uniform body of federal law. *Babikian v. Paul Revere Life Insurance Co.*, 63 F.3d 837, 840 (1995). The contract must be examined as a whole and contract terms should be interpreted "in an ordinary and popular sense as would a person of average intelligence and experience." *Id.* quoting *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (1990). "If a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy." *Evans*, 916 F.2d at 1441. However, if "two reasonable and fair interpretations are possible, an ambiguity exists." *Evanston Inc. Co. v. Fred A. Tucker & Co., Inc.*, 872 F.2d 278, 279 (9th Cir. 1989). Ambiguities must be resolved in favor of the insured. *Babikian*, 63 F.3d at 840.

Under the Fortis policy a "pre-existing condition" means a sickness or any related sickness for which Ms. Elliot (1) consulted with or received advice from a licensed medical practitioner or (2) received medical care, treatment, or services, including taking drugs, medicine,

insulin, or similar substances, during the 3 months that end on the day before Elliot became insured under the long term disability insurance policy.

Fortis will not pay benefits for any disability caused by such pre-existing condition until the earlier of:

> 3 consecutive months, ending on or after the day you became insured under the long term disability insurance policy, during which you do not consult with or receive advice from a licensed medical . . . practitioner or receive medical . . . care, treatment, or services, including taking drugs, medicine, insulin, or similar substances, for that condition; or
>
> 12 consecutive months during which you are continuously insured under the long term disability policy.

Fortis determined that the 3-month time period could not be satisfied because plaintiff was examined by physicians and received medication to prevent the reoccurrence of breast cancer from June 1996 through August 2000.

It is undisputed that plaintiff was examined by her oncologist for breast cancer during the three months preceding September 27, 1999. However, the medical records are uncontroverted and demonstrate that plaintiff did not have cancer between July of 1997 and September 27, 1999. It is also undisputed that plaintiff was prescribed, and took, Tamoxifen to lessen the chances of breast cancer reoccurring in the future. It was not prescribed to treat active disease or sickness. In fact, plaintiff's medical records reveal that Tamoxifen was discontinued when she was diagnosed with metastatic breast cancer in August, 2000.

The question the Court must answer is whether Elliot had a pre-existing condition during the three months preceding September 27, 1999. The issue boils down to whether, under the policy, Elliot actually had to have breast cancer *and* receive medical advice, care, treatment or services for breast cancer during the three months preceding September 27, 1999, or whether it was sufficient simply for Elliot to receive advice, care, treatment or services for breast cancer even though she was clinically free of the disease during such period of time. The Court is of the opinion that the former is the proper, and quite frankly only, interpretation of the policy.

"Pre-existing" means to exist before something. *The American Heritage Dictionary of the English Language* (Fourth Edition). That something is the day before Ms. Elliot became insured. The policy defines "condition" as a "sickness." Thus, interpreting these terms in their ordinary and popular sense as would a person of average intelligence and experience, the Court is bound to conclude that, to qualify as a pre-existing condition, Ms. Elliot's sickness must have existed during the three months that end on the day before she became insured.

The policy also states that Fortis will not pay benefits for any disability caused by a pre-existing condition. It is axiomatic that for a pre-existing condition to cause a disability, the insured must actually have had that condition at some time during the three months prior to the date the person became insured. A sickness that one did not have cannot cause a disability.

Even if this Court were to assume that Fortis's interpretation of the policy was reasonable, an ambiguity would

exist which would require the Court to resolve the ambiguity in Elliot's favor. *Babikian*, 63 F.3d at 840.

While Elliot was examined for breast cancer, her oncologist determined that she was cancer free during the three months preceding September 27, 1999. She simply did not have a sickness or pre-existing condition as required by the policy.

Fortis hangs its hat on the fact that Elliot took Tamoxifen during the three month period at issue. The Court does not find this contention persuasive for two reasons. First, it is undisputed that Tamoxifen was prescribed to lessen the chances that Elliot would develop breast cancer in the future, not to treat active disease or sickness. Second, as noted by the discussion above, Ms. Elliot did not have breast cancer during the relevant time period. In the absence of actual cancer, prophylactic measures to lessen the risk of developing cancer in the future do not constitute medical care, treatment, or services for cancer as these terms are used in the policy.

Fortis abused its discretion in denying benefits because it construed provisions of the plan in ways that conflict with the plain language of the plan and erred in its application of the law. *See Schikore, supra*.

While plaintiff is entitled to long term disability benefits under the policy, her prayer for emotional distress and punitive damages under ERISA must be dismissed. *Bast v. Prudential Insurance Co. of America*, 150 F.3d 1003 (9th Cir. 1998), 528 U.S. 870 (1999).

Based upon the foregoing, the Court enters the following ORDER:

1. Defendant's Motion for Judgment on the Pleadings and to Strike July Demand is granted. Plaintiff's state law claims are preempted by ERISA. The Court shall construe plaintiff's action as one under 29 U.S.C. § 1132(a)(1)(B) to recover benefits due to her under the terms of the Fortis plan.

2. Plaintiff's Rule 12(c) Motion for Judgment on the Pleadings on Defendant's Fifth Defense is denied.

3. Defendant's Motion for Summary Judgment on the ERISA claim is denied. Plaintiff is entitled to all long term disability benefits due under Fortis Policy No. G 71, 216.

4. All other pending motions are denied as moot.

The Clerk shall enter judgment accordingly and forthwith notify the parties of the making of this Order.

DONE and DATED this 7th day of November, 2001.

/s/ Richard F. Cebull
Richard F. Cebull
United States
District Judge

UNITED STATES DISTRICT COURT

DISTRICT OF MONTANA

BILLINGS DIVISION

STEPHANIE ELLIOT,

Plaintiffs,

v.

FORTIS BENEFITS INSURANCE CO.,

Defendant.

JUDGMENT IN A CIVIL CASE

CV 01-11-BLG-RFC

(Filed Jan. 2, 2002)

__ **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

X **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

THE PLAINTIFF'S MOTION FOR AN AWARD OF REASONABLE ATTORNEY'S FEES AND COSTS IN THE AMOUNT OF $15,490.15 IS GRANTED. (A copy of Order dated 12/21/01 is attached)

DATED: 1/2/02

/s/ **Patrick E. Duffy**
CLERK

/s/ **Susan L. Nybo**
DEPUTY CLERK

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
BILLINGS DIVISION

STEPHANIE ELLIOT, Plaintiff, vs. FORTIS BENEFITS INSURANCE CO., Defendant.	CR-01-011-BLG-RFC ORDER (Filed Dec. 21, 2001)

STATEMENT OF FACTS

On November 8, 2001, this Court entered judgment in this case which, among other things, entitled the plaintiff to recover disability benefits from the defendant. On November 20, 2001, the plaintiff filed a motion for an order awarding attorney's fees and costs pursuant to 29 U.S.C. § 1132(g)(1). The plaintiff is asking for $14,970.00 in attorney's fees, and $520.15 in costs.

ARGUMENTS

The plaintiff argues that she prevailed on her claim for disability benefits and she is entitled to attorney's fees and costs, absent a showing by the defendant of special circumstances that would make such an award unjust. The plaintiff acknowledges that because this Court ruled that her state law claims were preempted by ERISA, she is not entitled to attorney's fees and costs associated with the portion of her lawsuit based on claims of violations of the Unfair Trade Practices Act (specifically M.C.A. § 33-18-201).

The defendant argues that if fees are to be awarded, they should be reduced from the amount asked for by the plaintiff. The defendant asserts that the bulk of the plaintiff's efforts were directed to non-ERISA claims and arguments, which do not provide for an award of attorney's fees. They argue that the plaintiff did not promptly seek adjudication of her benefits under ERISA, instead she moved for partial summary judgment based on state law claims. The defendant provided the Court with a list of fees that are outside the scope of ERISA. The defendant argues that in the event this Court awards attorney's fees in this case, the amount properly awarded would be $11,890.15.

The plaintiff replies by asserting that they meet all of the factors required by the Ninth Circuit to award attorneys fees, and further, that the plaintiff should recover attorney's fees and costs unless there are special circumstances that would make such an award unjust.

ANALYSIS

The award of attorney's fees and costs to the prevailing party in an ERISA case are provided for in 18 U.S.C. 1132(g)(1) which states:

> In any action under this subchapter by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

The Ninth Circuit Court of Appeals has determined that certain factors must be met in order for a Court to award attorney's fees in a case such as this. *See Hummell v. Rykoff & Co.*, 634 F.2d 446, 453 (9th Cir. 1980). These factors include: (1) the degree of the opposing parties'

culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of fees; (3) whether an award of fees would deter others from acting under similar circumstances; (4) whether the party requesting fees sought to benefit all plan participants or resolve a significant legal question; and (5) the relative merits of the parties positions. *Id.* When applying these factors the Courts must keep at the forefront the remedial purposes of ERISA that should be liberally construed in favor of protecting the participants. *Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587, 589 (9th Cir. 1983). The Courts also apply a "special circumstances" rule in which a successful ERISA participant "should ordinarily recovery an attorney's fee unless special circumstances would render such an award unjust." *Id.* at 589.

This Court will apply each of the five *Hummell* factors to this case to determine if an award of attorney's fees and costs are appropriate. It is important to note that the *Hummell* factors are a balancing test and the Court does not need to find that each factor supports the plaintiff's claim. *Id.* at 590.

1. Degree of Opposing Parties Culpability or Bad Faith

As noted in the Court's order in this case, the medical records were uncontroverted and indicated that the plaintiff did not have cancer between July of 1997 and September 27, 1999. The plaintiff's policy issued by Fortis became effective on September 27, 1999. The defendants argued that the plaintiff had a "pre-existing condition" as defined by the policy, because during the three month period prior to her policy coverage, she was taking a drug

called Tamoxifen. This Court found the defendant's argument to be without merit, and concluded that the use of a prophylactic drug such as Tamoxifen does not by itself constitute a "pre-existing condition" as defined by the policy.

This Court found that the defendant abused its discretion in denying the benefits in this case, and further that the defendant's interpretation of the policy was unreasonable. Since the defendant's argument for denying benefits was without merit, we find that the defendant was at the very least culpable.

2. The Ability of the Opposing Party To Satisfy an Award of Fees

There has been no argument by the defendant that they would not be able to pay an attorney's fees that were awarded. This Court would have trouble finding that a large insurance company such as Fortis could not afford attorney's fees in this amount.

3. Whether an Award of Attorney's Fees Would Act as a Deterrent.

The Court agrees with the argument of the plaintiff on this point. A fee award would deter other insurers from forcing beneficiaries to undertake the costs of litigation in order to preserve their claims. Without the threat of attorney's fees, insurers could simply deny the claims of beneficiaries and wait until the claimant files suit to pay them their benefits. Such actions can be prevented when a possible award of substantial attorney's fees is available against the insurance company.

4. Whether the Parties Requesting Fees Sought to Benefit All Plan Participants or Resolve a Significant Legal Question.

The issue presented in this case was a significant legal question. Determining whether a prophylactic medication taken to prevent future recurrences of cancer constituted a "pre-existing condition" is significant. Under the defendant's interpretation of the plan, a woman who had no evidence of cancer in her body, but who was taking a potentially life-saving preventative medication would not be covered by their policy. Clearly these issues are compelling and significant.

5. The Relative Merits of The Parties Positions

As noted in the Court's order, the position of Fortis as to the interpretation of the policy was without merit. The medical evidence showed the plaintiff had no cancer. She was at the time taking a preventative medication to prevent further occurrences of cancer. Determining that these facts constituted a "pre-existing condition" was an abuse of discretion and consequently the arguments by the defendant had no merit.

This Court concludes that the *Hummell* factors support an order awarding reasonable attorney's fees and costs to the plaintiff. The defendant hasn't argued that there are special circumstances that indicate that an award would be unjust. This Court further finds that the arguments made by plaintiff's counsel as to her ERISA claim were reasonable and necessary and fees associated with this work should be awarded without any reduction. The foregoing factors, especially in light of the remedial purposes of ERISA, illustrate that the plaintiff's motion

for an award of reasonable attorney's fees and costs in the amount of $15,490.15 should be **GRANTED**.

The clerk is directed forthwith to notify counsel for both parties of the entry of this order.

DATED this 20th day of December, 2001.

/s/ Richard F. Cebull
RICHARD F. CEBULL
U.S. DISTRICT COURT
JUDGE

29 U.S.C.A. § 1132

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18 – EMPLOYEE RETIREMENT
INCOME SECURITY PROGRAM
SUBCHAPTER I – PROTECTION OF
EMPLOYEE BENEFIT RIGHTS
SUBTITLE B – REGULATORY PROVISIONS
PART 5 – ADMINISTRATION AND ENFORCEMENT

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (1) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title[1] or the

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[1] So in original. Probably should be "subtitle".

terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if –

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 1191b(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from

the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 1021(f)(1) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No

penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b-14(c)(8) of Title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this

subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan –

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of –

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the

Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of –

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this subtitle by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1) –

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and

beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that –

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

29 U.S.C.A. § 1144

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18 – EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I – PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE B – REGULATORY PROVISIONS
PART 5 – ADMINISTRATION AND ENFORCEMENT

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed

to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section –

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and

section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section –

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides –

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any

such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action –

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.

M.C.A. § 33-18-101. Purposes.

The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in Public Law 79-15 (the McCarran-Ferguson Act, 15 U.S.C. 1011 through 1015), which was approved March 9, 1945, by defining or providing for determination of all such practices in this state which constitute unfair methods of competition or unfair deceptive acts or practices and by prohibiting the trade practices so defined or determined.

M.C.A. § 33-18-102. Unfair methods or deceptive practices prohibited – refusal to renew.

(1) No person shall engage in this state in any trade practice which is defined in this chapter as or determined pursuant to this chapter to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

(2) Nothing in this chapter shall be construed to prevent an insurer owned or controlled by an association or organization, including a mutual insurer formed to provide insurance to the members of an association or organization, from refusing to renew a casualty or liability policy for nonpayment of dues to the association or organization if payment of dues is a condition for obtaining or continuing such insurance.

M.C.A. § 33-18-201. Unfair claim settlement practices prohibited.

No person may, with such frequency as to indicate a general business practice, do any of the following:

(1) misrepresent pertinent facts or insurance policy provisions relating to coverages at issue;

(2) fail to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) refuse to pay claims without conducting a reasonable investigation based upon all available information;

(5) fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) neglect to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(7) compel insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insured;

(8) attempt to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) attempt to settle claims on the basis of an application which was altered without notice to or knowledge or consent of the insured;

(10) make claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made;

(11) make known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) delay the investigation or payment of claims by requiring an insured, claimant, or physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) fail to promptly settle claims, if liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(14) fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

M.C.A. § 33-18-242. Independent cause of action – burden of proof

(1) An insured or a third-party claimant has an independent cause of action against an insurer for actual

damages caused by the insurer's violation of subsection (1), (4), (5), (6), (9), or (13) of 33-18-201.

(2) In an action under this section, a plaintiff is not required to prove that the violations were of such frequency as to indicate a general business practice.

(3) An insured who has suffered damages as a result of the handling of an insurance claim may bring an action against the insurer for breach of the insurance contract, for fraud, or pursuant to this section, but not under any other theory or cause of action. An insured may not bring an action for bad faith in connection with the handling of an insurance claim.

(4) In an action under this section, the court or jury may award such damages as were proximately caused by the violation of subsection (1), (4), (5), (6), (9), (13) of 33-18-201. Exemplary damages may also be assessed in accordance with 27-1-221.

(5) An insurer may not be held liable under this section if the insurer had a reasonable basis in law or in fact for contesting the claim or the amount of the claim, whichever is in issue.

(6) (a) An insured may file an action under this section, together with any other cause of action the insured has against the insurer. Actions may be bifurcated for trial where justice so requires.

(b) A third-party claimant may not file an action under this section until after the underlying claim has been settled or a judgment entered in favor of the claimant on the underlying claim.

(7) The period prescribed for commencement of an action under this section is:

(a) for an insured, within 2 years from the date of the violation of 33-18-201; and

(b) for a third-party claimant, within 1 year from the date of the settlement of or the entry of judgment on the underlying claim.

(8) As used in this section, an insurer includes a person, firm, or corporation utilizing self-insurance to pay claims made against them

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Cozzens, Warren & Harris, P.L.L.P.

Attorneys at Law

550 North 31st Street, Suite 250
Billings, Montana 59101

Lawrence B. Cozzens*
Paul M. Warren
Donald L. Harris
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dharris@cwh-trial-law.com

May 30, 2001

Robert Sterup
DORSEY & WHITNEY LLP
1200 First Interstate Center
401 North 31st Street
Billings, MT 59101

RE: Stephanie Elliot v. Fortis Benefits Insurance Company.
Cause No.: CV 01-11-BG JDS

Dear Rob,

Please advise Fortis that the Montana Power Company came to shut off the Elliot's power today. The Elliot's had to give the Montana Power Company their last $300.00 to keep the power on.

Sincerely yours,

/s/ Donald L. Harris
DONALD L. HARRIS

DLH/lh

Donald L. Harris
COZZENS, WARREN & HARRIS, P.L.L.P.
550 North 31st Street, Suite 250
Billings, MT 59101
Telephone: (406) 294-2000
Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
BILLINGS DIVISION

Stephanie Elliot, Plaintiff, vs. Fortis Benefits Insurance Company, Defendant.	Cause No. CV 01-11-BG JDS **COMPLAINT AND JURY TRIAL DEMAND** (Filed Jan. 19, 2001)

COMES NOW Plaintiff Stephanie Elliot and for her claims against Fortis Benefits Insurance Company, alleges as follows:

JURISDICTION

1. This Court has subject matter jurisdiction of this action under 29 U.S.C. § 1132 and 28 U.S.C. § 1332.

PARTIES

2. Plaintiff Stephanie Elliot is a citizen of the state of Montana. Defendant Fortis Benefits Insurance Company (Fortis) is a Minnesota corporation having its principal place of business in a state other than the State of Montana. The

matter in controversy exceeds, exclusive of interest and costs, the sum specified by 28 U.S.C. § 1332.

COUNT I

3. Stephanie Elliot is insured under Group Long Term Disability Insurance Policy No. G 71, 216 which Defendant Fortis issued to the law firm of Crowley, Haughey, Hanson, Toole & Dietrich (Crowley Law Firm). A complete copy of that policy is attached as Exhibit A and is by this reference incorporated herein. Ms. Elliot became an insured under that policy on September 27, 1999 when she was hired as a legal assistant by the Crowley Law Firm.

4. Ms. Elliot became totally disabled on August 19, 2000. On September 27, 2000, Ms. Elliot had been continuously insured under Policy No. G71, 216 for one year.

5. Under Montana law, a group disability insurer is prohibited from excluding coverage or denying benefits to an insured on the grounds that the insured's disability was caused by a pre-existing condition once the insured has been covered for one year under the group policy. *See* MCA § 33-22-514(1)(b).

6. Ms. Elliot applied for benefits under Policy No. G71, 216. Despite her request for disability benefits, Fortis wrongfully refuses to pay any disability benefits to Ms. Elliot on the grounds that her disability was caused by a pre-existing condition. *See* Exhibits B and C attached, which are by this reference incorporated herein.

7. Ms. Elliot's disability was not caused by a pre-existing condition, and Fortis has violated Montana law and the terms of Policy No. G71, 216 by denying Ms. Elliot disability

benefits even though she has been continuously insured under such policy for more than one year.

COUNT II

8. MCA § 33-22-514(1)(b), MCA § 33-18-201, and MCA § 33-18-242 are Montana statutes which regulate insurance. In excluding coverage and denying disability benefits to Ms. Elliot, Fortis has violated MCA § 33-22-514(1)(b) and MCA § 33-18-201(1), (4) and (6).

9. In violating MCA § 33-22-514(1)(b) and MCA § 33-18-201(1), (4) and (6), Fortis acted with actual malice and/or actual fraud as defined under MCA § 27-1-221.

WHEREFORE, Stephanie Elliot prays that she recover all damages allowed under the laws of the United States and the State of Montana including:

1. All disability benefits to which she is entitled to receive under Policy No. G71, 216;

2. Her attorneys' fees and costs;

3. Compensatory damages, including damages for emotional distress and mental anguish, caused by Fortis' wrongful refusal to pay her the disability benefits which she is entitled to receive;

4. Punitive damages; and

5. All such further relief as this Court or jury deems just and proper.

The Plaintiff hereby demands a trial by jury.

DATED this 19th day of January, 2001

COZZENS, WARREN &
HARRIS, P.L.L.P.

By /s/ Donald L. Harris
DONALD L. HARRIS
500 North 31st Street,
Suite 250
Billings, MT 59101

Attorneys for Plaintiff

EXHIBIT

A

Same as Exhibit B Attached to Kratochvil Affidavit
(See App. at 91-136)

EXHIBIT

B

Cozzens, Warren & Harris, P.L.L.P.

Attorneys at Law

550 North 31st Street, Suite 250
Billings, Montana 59101

Lawrence B. Cozzens
Paul M. Warren
Donald L. Harris

Telephone: (406) 294-2000
Fax: (406) 294-2010

December 5, 2000

Alex MacGillis
Fortis Benefits Insurance Company
P.O. Box 39844
Minneapolis, MS [sic] 55439-0844

Via Facsimile
(952) 920-4577

Dear Mr. MacGillis,

Re: Fortis Claim No.: 71216-0-0-108

Thank you for returning my phone call yesterday and for letting me know the status of Fortis' review of Stevie Elliott's claim for disability benefits. As I mentioned yesterday, Mrs. Elliott has retained our firm to represent her with regard to her disability claim.

From speaking with you yesterday, I understand that Fortis is reviewing Mrs. Elliott's claim to determine whether it can deny her claim because of a pre-existing condition. I further understand that Fortis has requested and received all of the medical records which Fortis deems relevant. Those records are now being reviewed by Fortis, and you stated that Fortis will be making a decision on Mrs. Elliott's claim within the next two weeks.

It is my understanding from our conversation that Fortis intends to deny Mrs. Elliott's claim if Fortis concludes that Mrs. Elliott became disabled by a pre-existing condition within twelve months of when she became insured under the Crowley Law Firm Group Disability Policy. You stated yesterday that Mrs. Elliott become insured under the Crowley Group Policy on September 27, 1999. That is the date that Mrs. Elliott become re-employed by the Crowley Firm.

Yesterday, you read me policy language from what you described as a "standard policy" which you believe excludes coverage for any disability caused by a pre-existing condition which arises within the first twelve months a person is insured under the Group Plan which Fortis issued to the Crowley Law Firm. The language which you read to me over the phone does not appear in the certificate for Group Policy 71,216 which Fortis issued to the Crowley Law Firm. I appreciate your offer to send me a copy of the policy from which you were reading.

Based upon the language which you read to me, I understand that Fortis intends to deny Mrs. Elliott's claim if Fortis concludes that Mrs. Elliott became disabled by a pre-existing condition within twelve months after she became insured on September 27, 1999. Before denying Mrs. Elliott's claim, I strongly urge you to contact Mrs.

Elliott's treating physician, Dr. Patrick Cobb, and to review Montana law as well as the clear language of the Crowley Law Firm Group Disability Certificate.

If you contact Dr. Cobb, he will tell you that Mrs. Elliott was disease-free and had no indications of cancer during the three months before she became insured under the Crowley Group Disability Plan. This fact seems particularly significant given that, as defined in the certificate, a "pre-existing condition" encompasses only those sicknesses which arose during the three months before Mrs. Elliott became insured. Again, I strongly urge you to contact Dr. Cobb directly if you feel that Mrs. Elliott had cancer during the time period between June 27, 1999 and September 27, 1999. Dr. Cobb will tell you that there was absolutely no medical or clinical basis for believing that Mrs. Elliott had cancer during that time period.

I also strongly urge you to review the policy language set forth in the Crowley Law Firm Certificate as well as Montana law with regard to when coverage for disabilities caused by pre-existing condition can be denied. There is no dispute that Mrs. Elliott has now been continuously insured under the Crowley Law Firm Disability Plan for more than one year. There is no dispute that Mrs. Elliott is completely disabled. Montana Law prohibits a group disability insurer from excluding coverage for a disability caused by a pre-existing condition for more than twelve months. M.C.A. § 33-22-514(1)(b) provides as follows:

> (1) A group health plan or a health insurance issuer offering group health insurance coverage may not exclude coverage for a pre-existing condition unless:
>
> . . . .

> (b) exclusion of coverage extends for a period of not more than 12 months . . .

The Crowley Law Firm Group Disability Certificate appears to comply with Montana law by stating that benefits for disabilities caused by pre-existing conditions will be paid once the insured has been continuously insured for twelve consecutive months.

> We will not pay benefits for any "disability" caused by a pre-existing condition (defined below) until the earlier of:
>
> . . . .
>
> 12 consecutive months during which you are continuously insured under the "long term disability insurance policy.

Given M.C.A. § 33-22-514(1)(b) and the language of the Crowley Law Firm Group Disability Certificate issued by Fortis, Fortis' concern that Mrs. Elliott may have been disabled by a pre-existing condition is misplaced. Even if Fortis were to ignore Dr. Cobb's opinion that Mrs. Elliott did not have cancer during the 90 days before she became insured, the fact remains that Mrs. Elliott became entitled to disability benefits once she had been insured for twelve months. That date was September 27th of this year.

Under the facts and law, it is clear that Mrs. Elliott is entitled to disability benefits under the Fortis Group Policy issued to the Crowley Law Firm. I strongly urge you to expedite payment of the benefits Mrs. Elliott is entitled to receive. I am sure you are aware that Fortis' delay in paying disability benefits to Mrs. Elliott is causing her to suffer a great deal of distress and mental anguish. On top of battling a very serious, life-threatening illness, Mrs.

Elliott now must worry about the possible loss of her home and the impending financial crisis which her disability insurance was there to prevent. If Fortis denies Mrs. Elliott's claim for disability benefits, we are prepared to immediately file suit against Fortis to recover both compensatory and punitive damages.

Please feel free to contact me if I can provide you with any additional information. It is my hope that Fortis will accept Mrs. Elliott's claim and promptly pay her the benefits she is entitled to receive so that she can focus all her energy and resources toward winning her battle against the cancer which now disables her.

Sincerely yours,
/s/ Donald L. Harris
DONALD L. HARRIS

EXHIBIT C

January 5, 2001

FORTIS
Solid partners, flexible solutions℠
[Address Omitted In Printing]

Cozzens, Warren & Harris, P.L.L.P.
Donald Harris
550 North 31st St, Suite 250
Billings, MT 59101

RE: Your Long Term Disability Claim
LTD Policy #71216-0-0-108

Dear Mr. Harris:

We have completed our review of Stephanie Elliot's long term disability claim. Please refer to the policy:

Pre-Existing Conditions

We will not pay benefits for any *disability* caused by a pre-existing condition (defined below) until the earlier of:

- 3 consecutive months, ending on or after the day you became insured under the *long term disability policy*, during which you do not consult with or receive advice from a licensed medical or dental practitioner or receive medical or dental care, treatment or services, including taking drugs, medicine, insulin, or similar substances, for that condition; or

- 12 consecutive months during which you are continuously insured under the *long term disability insurance policy*.

A "pre-existing condition" means an *injury*, sickness, or pregnancy or any related *injury*, sickness, or pregnancy for which you:

- consulted with or received advice from a licensed medical or dental practitioner; or

- received medical or dental care, treatment, or services, including taking drugs, medicine, insulin, or similar substances

during the 3 months that end on the day before you became insured under the *long term disability insurance policy*.

and;

Period of Disability means the time that begins on the day you become *disabled* and ends on the day before you return to *active work*. If you satisfy the *qualifying period* and then:

- return to *active work*;
- become *disabled* again; and
- remain insured under the *policy*;

the same *period of disability* may continue. Your return to *active work* must be for less than:

- 6 months, if the later *disability* results from the same cause, or a related one; or
- 1 day, if the later *disability* results from a different cause.

and;

Qualifying period means the length of time during a *period of disability* that you must be *disabled* before benefits are payable. If you satisfy the Earnings Test during the entire *qualifying period*, the Maximum Interruption During Qualifying Period in the Schedule will not apply. If application of the Occupation Test and the Maximum Interruption During Qualifying Period would result in an earlier entitlement to benefits, we will apply those provisions instead of the Earnings Test. In satisfying the Occupation Test, if you:

- return to *active work* during the *qualifying period* for no more than the maximum number of days shown in the Schedule;
- remain insured under the *policy*; and
- become *disabled* again for the same cause or one related to it;

you will not have to satisfy again the part of the *qualifying period* that you have already fulfilled.

> In any case, you cannot satisfy any part of the *qualifying period* by any *period of disability* that results from a cause for which we do not pay benefits.

Stephanie Elliot's initial Claim Statement was completed by Dr. Patrick Cobb on October 11, 2000. Dr. Cobb indicated that Mrs. Elliot had a diagnosis of metastatic breast cancer that affected her brain and bone. We requested Mrs. Elliot's medical records from Northern Rockies Cancer Center, Yellowstone Dermatology, St. Vincent's Hospital, Dr. Janet Dietrich, Albertson's Pharmacy, and Osco Drug, to determine if her medical condition was pre-existing.

According to the medical information we received, Mrs. Elliot had a three month checkup for breast cancer on September 16, 1999. On December 12, 1999, Mrs. Elliot consulted with Dr. Hammond for a breast cancer checkup. On March 23, 2000, she saw Dr. Hammond regarding her history of breast cancer with bone metastases. On March 24, 2000, Mrs. Elliot's history of breast cancer was noted in an annual examination with Dr. Dietrich. On April 6, 2000, she consulted with Dr. Hammond for an acute skin rash. A biopsy was done to determine if the rash was related to recurring tumors from her breast cancer. On June 8, 2000, Mrs. Elliot consulted with Dr. Hammond for a follow-up of her breast cancer.

At the onset of her current period of disability, Mrs. Elliot had increased headaches and pain. A subsequent CT scan showed evidence of metastatic disease in her brain. A MRI showed metastses [sic] in both lobes of her cerebellum and cerebrum. A bone scan showed possible tumors in her left humerus, left lower rib, and spine.

Mrs. Elliot was receiving Tamoxifen, a medication used for the treatment of cancer in reproductive tissues, including breasts. The pharmacy records received indicate Tamoxifen prescriptions dispensed on June 20, 1999, July 28, 1999, August 31, 1999, October 4, 1999, November 2, 1999, December 4, 1999, January 6, 2000, February 3, 2000, March 7, 2000, April 6, 2000, May 7, 2000, June 8, 2000, and July 9, 2000.

On January 3, 2001, Dr. Cobb's office confirmed that Mrs. Elliot's tumors were due to metastases from breast cancer. It was also confirmed that the Tamoxifen Mrs. Elliot was prescribed was being used to prevent recurrence of breast cancer and it's [sic] metastasis.

Mrs. Elliot's Long Term Disability insurance coverage became effective September 27, 1999. She became disabled on August 19, 2000. Information received from Mrs. Elliot's physicians and pharmacies indicate that between June 27, 2000, and August 19, 2000, there is no 3 month period for which she did not receive treatment or consultation for her disabling condition or a related condition. According to the terms of the policy, Mrs. Elliot's condition is pre-existing and benefits are not payable on this claim.

We regret we are unable to extend benefits on this claim. If you disagree with our determination, you may request a claim review. Enclosed are the procedures for requesting such a review. If you do choose to appeal, please include a written explanation of your disagreement with our decision and any medical information that indicates Mrs. Elliot's disabling condition is not pre-existing.

Sincerely,

/s/ Alexander G. MacGillis
Alexander MacGillis
Disability Claims Specialist
(800) 325-8385 x-2955
agmacgillis@us.fortis.com

Robert L. Sterup
Dorsey & Whitney LLP
401 N. 31st St.
1200 First Interstate Center
P.O. Box 7188
Billings, MT 59101
(406) 252-3800

Attorneys for Defendant Fortis Benefits Insurance Company

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
BILLINGS DIVISION

Stephanie Elliott, Plaintiff, v. FORTIS BENEFITS INSURANCE COMPANY, Defendants.	)	Cause No. CV 01-11-BLG-JDS **ANSWER OF DEFENDANT FORTIS BENEFITS INSURANCE COMPANY**

Fortis Benefits Insurance Company ("Fortis") for its Answer to Plaintiff's Complaint, admits, denies, and states as follows:

FIRST DEFENSE

1. Upon information and belief, admits the allegations of paragraph 1.

COUNT ONE

2. Admits Plaintiff is a Montana citizen, and that Plaintiff seeks the amount claimed; further states the Court has jurisdiction under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132 et seq.

3. Admits the referenced policy was so numbered; states and alleges the written document speaks for itself; admits Plaintiff's effective date under the subject Group Long Term Disability ERISA Plan was September 27, 1999; upon information and belief admits the Plaintiff was employed by the Crowley Law Firm.

4. Upon information and belief, admits Plaintiff's last date worked was August 18, 2000 and the onset date was August 19, 2000; denies the remaining allegations of this paragraph.

5. Denies the allegations of paragraph 5.

6. Admits Plaintiff sought benefits; denies the remaining allegations of this paragraph.

7. Denies the allegations of paragraph 7.

COUNT II

8. Denies the allegations of paragraph 8.

9. Denies the allegations of paragraph 9.

Fortis denies each and every allegation, averment, statement or thing not specifically admitted or denied above.

By way of additional defense, Defendant states and alleges as follows.

SECOND DEFENSE

Plaintiff's Complaint and each of its purported claims for relief fail to state facts sufficient to constitute claims upon which relief can be granted against Fortis.

THIRD DEFENSE

Fortis is informed and believes, and upon such information and belief alleges, that if plaintiff sustained any injury, damage, or loss, other parties or individuals, excluding Fortis, were negligent or at fault or otherwise legally responsible for the injuries, losses, or damages alleged in the Complaint. This conduct of other parties comparatively reduces or eliminates the liability, if any, of Fortis.

FOURTH DEFENSE

Fortis has fully performed under the terms of the Policy. As a consequence, Fortis is excused from further performance, and Plaintiff is barred and estopped from asserting against Fortis the claims stated in the Complaint.

FIFTH DEFENSE

The Complaint, and each of its claims for relief, is subject to and preempted by ERISA. Accordingly, Plaintiff is not entitled to any recovery not permitted under ERISA.

SIXTH DEFENSE

Fortis's actions with respect to Plaintiff's claim, were taken in good faith and were a lawful exercise of sound discretion and Fortis's legal rights, and were based on a rational, reasonable consideration of the facts.

SEVENTH DEFENSE

Fortis's claims decision was proper under the applicable standard of ERISA review, and therefore must be upheld. Therefore, Plaintiff is not entitled to further Policy benefits.

EIGHTH DEFENSE

A jury trial is not available under ERISA.

NINTH DEFENSE

Each of Plaintiff's claims set forth in her Complaint is barred to the extent she failed to exhaust her administrative remedies.

TENTH DEFENSE

Fortis is not the proper party.

WHEREFORE, Defendant prays for judgment as follows:

1. That Plaintiff's Complaint be dismissed with prejudice and that Plaintiff take nothing by her Complaint;

2. That the Court declare that plaintiff is not entitled to recovery of Policy benefits;

3. For costs and such other and further relief as the court deems just and equitable.

Dated this 15th day of February, 2001

DORSEY & WHITNEY LLP

By /s/ Robert Sterup
Robert Sterup, Esq.
Dorsey & Whitney LLP
1200 First Interstate Center
401 North 31st Street
Billings, Montana 59101
(406) 252-3800

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing was served by First Class Mail upon the following this 15th day of February, 2001, at the following address:

Donald L. Harris
Cozzens, Warren & Harris, P.L.L.P.
550 North 31st Street, Suite 250
Billings, MT 59101

/s/ Llanne Beatty
Secretary to Robert L. Sterup

Donald L. Harris
COZZENS, WARREN & HARRIS, P.L.L.P.
550 North 31st Street, Suite 250
Billings, MT 59101
Telephone: (406) 294-2000

Attorneys for Plaintiff

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
BILLINGS DIVISION**

Stephanie Elliot, Plaintiff, v. Fortis Benefits Insurance Company, Defendant.	)	Cause No.: CV 01-11-BG-JDS **AFFIDAVIT OF DR. PATRICK W. COBB**

STATE OF MONTANA)
) :SS
County of Yellowstone)

I, Dr. Patrick W. Cobb, being first duly sworn, upon oath state:

1. I am Dr. Patrick W. Cobb. I received my medical degree from Tulane University and I am Board Certified in internal medicine, hematology, and oncology. I have been licensed to practice medicine in the State of Montana since 1995. I have been practicing medicine in Billings, Montana with Billings Oncology Associates.

2. Stephanie "Stevie" Elliot is presently a patient of mine. She was previously seen by my former partner Dr. Neil Hammond. I have carefully reviewed Ms. Elliot's medical records with regard to her past and present treatment for cancer.

3. Attached as Exhibit A is a copy of a January 16, 2001 letter I wrote to Alexander MacGillis of Fortis Benefits Insurance Company. That letter summarizes Ms. Elliot's medical history with regard to cancer.

4. As set forth in my letter of January 16, 2001, it is my professional opinion to a reasonable degree of medical certainty based upon my review of Ms. Elliot's medical records and my own evaluation and treatment of Ms. Elliot that:

a) Ms. Elliot was successfully treated for and recovered from the breast cancer which she had in December 1995.

b) Ms. Elliot was placed on Tamoxifen beginning in July 1996 to prevent cancer from recurring. Tamoxifen was not prescribed for Ms. Elliot for the treatment of any active cancer or other disease.

c) Ms. Elliot underwent standard, periodic testing for the presence of cancer throughout 1999.

d) In 1999, none of Ms. Elliot's test results showed any indication that Ms. Elliot had cancer, nor did Ms. Elliot have any other signs or symptoms of cancer in 1999.

e) There is no medical basis for asserting that Ms. Elliot had cancer during the three month time period before September 27, 1999.

5. I am currently treating Ms. Elliot for cancer of the brain and bone which was diagnosed for the first time in August 2000. Ms. Elliot is seriously ill and is totally disabled.

DATED this 23rd day of March, 2001.

/s/ Patrick Cobb, M.D.
DR. PATRICK W. COBB

SUBSCRIBED AND SWORN to before me this 23rd day of March, 2001.

/s/ Phyllis J. [Illegible]
Notary Public for the State of Montana, Residing at Billings, Montana.

(NOTARIAL SEAL)

My commission expires: 10-31-04

EXHIBIT A

[logo]

BILLINGS ONCOLOGY ASSOCIATES

Oncology • Hematology.

Benjamin T. Marchello, M.D.
Gerardo Midence, M.D.
Patrick W. Cobb, M.D.
Martin Barnett, M.D.
Tom Anderson, M.D.

January 16, 2001

Alexander MacGillis
Disability Claims Specialist
Fortis Benefits Insurance Co.
P.O. Box 39844
Minneapolis, MN 55439-0844

RE: STEPHANIE ELLIOT

Dear Mr. MacGillis:

This is in regards to the case of Stephanie Elliot (LTD Policy #71216-0-0-108). I think I should try and clarify some of the statements that have been made so far about Mrs. Elliot's case.

Mrs. Elliot was originally diagnosed with breast cancer in December 1995. She underwent a right modified radical mastectomy for a 2.8 cm. tumor. Seventeen lymph nodes were examined in the axilla and all 17 were positive. The patient had a preoperative bone scan that was read as normal, but a CT scan was performed which was read as possibly consistent with metastatic disease at T-7 and T-12, C-3, L-1 and L-4 in the spine. The patient underwent three cycles of Doxorubicin, 5-FU, and Methotrexate prior to high dose chemotherapy and stem cell transplant at Duke University. She was treated with high dose Cyclophosphamide, BCNU, and Cisplatin and received her stem cells on 4-21-96. After the transplant, she received radiation therapy to the bone, the chest wall, and the axilla. The patient had been examined on multiple occasions by my partner, Dr. Hammond, who had not found any evidence of recurrent disease.

The patient was placed on tamoxifen in July 1996 after her transplant had been completed. The tamoxifen was given not to specifically treat metastatic disease, but as adjuvant therapy to increase the possibility that she would have an ultimate cure from her disease.

The patient remained asymptomatic without evidence of recurrent cancer until I saw her on 8-19-00 in the Emergency Room after she complained of headaches. She was found to have metastatic disease in the brain and bone at

that time. She has now undergone radiation therapy and is currently receiving oral hormonal agents and Pamidronate for her metastatic disease.

The patient had no objective evidence of metastatic disease until I saw her in the hospital in August 2000. The patient had been seen on multiple occasions by my former partner, Dr. Hammond, and he had never documented any evidence of recurrent disease. Therefore, the patient did not have a diagnosis of metastatic breast cancer until I saw her on 8-19-00.

Please do not hesitate to contact my office if you have any questions regarding Mrs. Elliot's care.

Sincerely,

Patrick Cobb, M.D.

PC:nas

D: 1-16-01 T: 1-16-01

cc Gary Connelley
500 Transwestern Plaza II
490 N. 31st St.
Billings, MT 59101

Donald L. Harris
COZZENS, WARREN & HARRIS P.L.L.P.
550 North 31st Street, Suite 250
Billings, MT 59101
Telephone: (406) 294-2000

Attorneys for Plaintiff

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
BILLINGS DIVISION**

Stephanie Elliot, Plaintiff, v. Fortis Benefits Insurance Company, Defendant.	)	Cause No.: CV 01-11-BG JDS **AFFIDAVIT OF CINDY KRATOCHVIL**
STATE OF MONTANA County of Yellowstone	)	: SS

I, Cindy Kratochvil, being first duly sworn, upon oath state:

1. I am Cindy Kratochvil. I am the Administrative Assistant for the law firm of Crowley, Haughey, Hanson, Toole & Dietrich (Crowley Law Firm) and have been employed in that capacity since November 1, 1989.

2. As part of my duties, I am responsible for assisting in the hiring of staff, such as secretaries and legal assistants, and of helping eligible employees to apply for disability benefits. I have personal knowledge of when Stephanie Elliot was hired, her compensation, the disability

benefits she received from the Crowley Law Firm, and about her application for disability benefits from Fortis Benefits Life Insurance Company.

3. The Crowley Law Firm hired Ms. Elliot as a paralegal on September 27, 1999. At that time, Ms. Elliot also became automatically insured under the Group Long Term Disability Insurance Policy which Fortis Benefits Insurance Company had issued to the Crowley Law Firm. A true and accurate copy of that policy is attached to this Affidavit as Exhibit B.

4. Ms. Elliot was hired as a full-time employee. She was employed as a full-time legal assistant at the Crowley Law Firm from her date of hire on September 27, 1999 until she became disabled in August 2000. The last day that Ms. Elliot was able to work at the Crowley Law Firm was Friday, August 18, 2000. Ms. Elliot was a salaried employee and, at the time she became disabled, she was earning $32,000.00 a year or approximately $615.38 per week.

5. Under the Crowley Law Firm disability program, the Crowley Law Firm pays for 100% of the premium for disability benefits for an employee for the first $20,000.00 of an employee's annual salary. The employee has the option of paying the additional premium necessary to cover any salary which the employee earns over $20,000.00. In Ms. Elliot's case, the Crowley Law Firm has paid for the premium to provide disability benefits to Ms. Elliot based upon the first $20,000.00 of her salary. Ms. Elliot then paid the additional premium necessary to cover the next $12,000.00 of her salary. The Crowley Law Firm has continued to pay Ms. Elliot's premium for the first $20,000.00 of her salary. Ms. Elliot paid the additional

premium necessary to cover the amount of her salary over $20,000.00 from September 27, 1999 through December of 2000.

6. I assisted Ms. Elliot in completing the Fortis Benefits disability claims form, a copy of which is attached to this Affidavit as Exhibit C. I submitted that form to Fortis Benefits Insurance Company on Ms. Elliot's behalf on October 17, 2000. A copy of that letter is attached to this Affidavit as Exhibit D.

7. The Crowley Law Firm paid Ms. Elliot short-term disability benefits equal to 100% of Ms. Elliot's salary for the first ninety days of her disability. Those benefits began on August 21, 2000 and ended on November 20, 2000. In her claim for disability benefits from Fortis, Ms. Elliot sought long-term disability benefits beginning November 21, 2000.

8. Ms. Elliot has been continuously insured under the Fortis Group Long Term Disability Insurance Policy since September 27, 1999.

DATED this 26th day of March, 2001.

/s/ Cindy Kratochvil
CINDY KRATOCHVIL

SUBSCRIBED AND SWORN to before me this 26th day of March, 2001.

/s/ Donald L. Harris
Notary Public for the State
of Montana, Residing at
Billings, Montana

(NOTARIAL SEAL)

My commission expires: 8/01/03

EXHIBIT B

fortis

Fortis Benefits
Insurance Company
St. Paul, Minnesota • Kansas City, Missouri

Fortis Benefits Insurance Company agrees to provide the insurance described in this and the following pages of the *policy*, subject to payment of premiums.

Policyholder:	Crowley, Haughey, Hanson, Toole & Dietrich
Policy Number:	G 71,216
Delivered In:	Montana and governed by its laws.
Effective Date:	January 1, 1995 – The date the *policy* takes effect which is also its date of issue.
Premium Due Dates:	The first premium is due on the Effective Date. Future premiums are due on the first day of each month after that.
Policy Anniversary:	January 1, 1996, and each January 1 after that.
Insurance Provided:	**Group Long Term Disability Insurance – Noncontributory/Contributory 24-Hour**

/s/ Robert R. Zanabri
Secretary

/s/ [Illegible]
President

Attest:

Registrar

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GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns "we", "us", "our", "you", and "your" are not *italicized*.

Active work means working *full-time* for the *policyholder* or an *associated company* at your usual place of business.

Associated company means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

Contributory means you pay part of the premium.

Covered person means an eligible employee or member of the *policyholder*, or an *associated company* who has become insured for a coverage.

Doctor means a person, other than you, acting within the scope of his or her license to practice medicine and perform surgery.

Eligible class means a class of persons eligible for insurance under the *policy*. This class is based on employment or membership in a group.

Full-time means working at least 20 hours per week, unless indicated otherwise in the *policy*.

Home office includes our Home Office located in St. Paul, Minnesota, and our office in Kansas City, Missouri.

Injury means accidental bodily injury. It does not mean intentionally self-inflicted injury while sane or insane.

No-fault motor vehicle coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

Noncontributory means the *policyholder* pays the premium.

Policy means the group policy issued by us to the *policyholder* that describes the benefits for which you may be eligible.

Policyholder means the entity to whom the *policy* is issued.

Proof of good health means evidence acceptable to us of the good health of a person.

We, us, and our mean Fortis Benefits Insurance Company.

You and your mean an employee or member of the *policyholder* or an *associated company* who has met all the eligibility requirements for a coverage.

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE

Accommodation expense means the costs your employer incurs to accommodate your disability, as required by the Americans with Disabilities Act or similar legislation. It also means costs you incur for tools, equipment, furniture, computer software, or other items necessary for you to return to work. The amount of the *accommodation expense* will be limited to $2,000 for each *period of disability*.

Disability or *disabled* means that in a particular month, you satisfy either the Occupation Test or the Earnings Test, as described below. You may satisfy both the Occupation Test and Earnings Test, but you need only satisfy one Test to be considered *disabled*.

Occupation Test

If you are a *covered person* in Class I or Class II:

- during a *period of disability* (including the *qualifying period*), an *injury*, sickness, or pregnancy requires that you be under the *regular care and attendance* of a *doctor*, and prevents you from performing at least

one of the *material duties* of your specialty, if your employment is based upon the performance of your specialty.

If you are a *covered person* in Class III:

during a *period of disability* (including the *qualifying period*), an *injury*, sickness, or pregnancy requires that you be under the *regular care and attendance* of a *doctor*, and prevents you from performing at least one of the *material duties* of your regular occupation.

If you are a *covered person* in Class IV:

- during the first 36 months of a *period of disability* (including the *qualifying period*), an *injury*, sickness, or pregnancy requires that you be under the *regular care and attendance* of a *doctor*, and prevents you from performing at least one of the *material duties* of your regular occupation; and
- after 36 months of *disability*, an *injury*, sickness, or pregnancy prevents you from performing at least one of the *material duties* of each *gainful occupation* for which your education, training, and experience qualifies you.

Earnings Test

You may be considered *disabled* in any month in which you are actually working, if an *injury*, sickness, or pregnancy, whether past or present, prevents you from earning more than 80% of your *monthly pay* in that month in any occupation for which your education, training or experience qualifies you. On each anniversary of the date your *disability* started, we will increase by 7.5% the *monthly pay* figure we use to decide whether you are *disabled* under this test. This increase will not affect the amount of benefit we pay.

If your actual earnings during any month are more than 80% of your *monthly pay* (including the 7.5% increase(s)), you will not be considered *disabled* under the Earnings Test during that month. Salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income you receive or are entitled to receive will be included. However, sick pay and salary continuance for periods not at work will not be included. Any lump sum payment will be pro-rated, based on the time over which it accrued or the period for which it was paid.

You may still be considered *disabled* according to the Occupation Test, without regard to your level of current earnings, if you meet the requirements of that Test.

If you meet the Earnings Test, *full-time* work in which you are performing all of the *material duties* of your regular or some other occupation will not interrupt the *qualifying period* or the *period of disability*. If you meet the Occupation Test only, work on less than a *full-time* basis of work in which you are not doing all of the *material duties* of your regular occupation, will not interrupt the *qualifying period* or the *period of disability*.

Education expense means, in your *rehabilitation plan*, the reasonable costs you incur which are required for your education or training to return to work. These costs may include the cost of tuition, books, computers and other equipment. In your spouse's *rehabilitation plan, education expense* means the reasonable costs your spouse incurs which are required for your spouse's education or training. These costs may include the cost of tuition, books, computers, and other equipment.

Family care expense means the amount you spend for care of a family member in order for you to work or be retrained under a *rehabilitation plan*. To qualify:

- your family member must be under age 13, or be physically or mentally incapable of caring for him or herself;
- your family member must be dependent on you for support and maintenance; and
- the person who cares for your family member cannot be a relative.

Not more than $350 per family member per month will be included. A prorated amount will apply to any period shorter than a month.

Gainful occupation means, for the purpose of the Occupation Test, an occupation in which you could reasonably be expected to earn at least as much as your Schedule Amount.

Government plan means the United States Social Security Act, the Railroad Retirement Act, the Canadian Pension Plan, similar plans provided under the laws of other nations, and any plan provided under the laws of a state, province, or other political subdivision. It also includes any public employee retirement plan or any teachers' employment retirement plan, or any plan provided as an alternative to any of the above acts or plans. It does not include any Workers' Compensation Act or similar law, or the Maritime Doctrine of Maintenance, Wages, or Cure.

Hospital means a facility supervised by 1 or more *doctors* and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical

dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital confined and *hospital confinement* mean staying in a *hospital* for 24 hours a day.

Long term disability insurance means the group long term disability insurance provided under the *policy*.

Material duties means the sets of tasks or skills required generally by employers from those engaged in a particular occupation. One *material duty* of your regular occupation is the ability to work for an employer on a *full-time* basis as defined in the *policy*.

Medical expense means the reasonable costs you incur for medical treatment, physical therapy, and adaptive equipment necessary for your vocational rehabilitation, in excess of amounts paid or payable by third parties and any amounts under a policy of major medical coverage.

Mental illness means neurosis, psychoneurosis, psychopathy, psychosis, depression, eating and sleeping disorders, or mental or emotional diseases or disorders of any kind including those caused by chemical imbalance. It does not include dementia, organic brain syndromes, delirium, amnesia syndromes or organic delusional or hallucinogenic syndromes.

Moving expense means the costs you incur to move more than 35 miles so that you can attend school or accept gainful work. In a spouse's *rehabilitation plan*, the costs are those incurred by the family so that the spouse can attend school or accept gainful work.

Other plan means any group disability plan sponsored by your employer, the *policyholder*, or an *associated company*, except the one provided under the *policy*.

Period of disability means the time that begins on the day you become *disabled* and ends on the day before you return to *active work*. If you satisfy the *qualifying period* and then:

- return to *active work*;
- become *disabled* again; and
- remain insured under the *policy*;

the same *period of disability* may continue. Your return to *active work* must be for less than:

- 6 months, if the later *disability* results from the same cause, or a related one; or
- 1 day, if the later *disability* results from a different cause.

If your return to *active work* meets either of the above conditions, you do not have to satisfy the *qualifying period* again. The Maximum Benefit Period will continue on the day you become *disabled* again.

If you return to *active work* for more than the time shown above, and then become *disabled* again, you will start a new *period of disability*. You must satisfy the *qualifying period* again and the Maximum Benefit Period will start over.

Qualifying medical condition means a life-threatening condition where you have an expected life span of 12 months or less.

Qualifying period means the length of time during a *period of disability* that you must be *disabled* before benefits are payable. If you satisfy the Earnings Test during the entire *qualifying period*, the Maximum Interruption During Qualifying Period in the Schedule will not apply. If application of the Occupation Test and the Maximum Interruption During Qualifying Period would result in an earlier entitlement to benefits, we will apply those provisions instead of the Earnings Test. In satisfying the Occupation Test, if you:

- return to *active work* during the *qualifying period* for no more than the maximum number of days shown in the Schedule;
- remain insured under the *policy*; and
- become *disabled* again for the same cause or one related to it;

you will not have to satisfy again the part of the *qualifying period* that you have already fulfilled.

In any case, you cannot satisfy any part of the *qualifying period* by any *period of disability* that results from a cause for which we do not pay benefits.

Regular care and attendance means care at a frequency medically appropriate for your condition. If your condition does not require frequent visits to your *doctor*, neither will we.

Rehabilitation plan means a written agreement between you and us in which, at your request, we agree to provide, arrange, or authorize appropriate vocational or physical rehabilitation services.

A spouse's *rehabilitation plan* means a written agreement between you, your spouse, and us in which, at your request, we agree to provide, arrange or authorize appropriate vocational or physical rehabilitation services.

Retirement plan means a formal or informal retirement plan, whether or not under an insurance or annuity contract. It does not include:

- a plan you pay for entirely;
- a qualified profit-sharing plan;
- a thrift plan;
- an individual retirement account (IRA);
- a tax sheltered annuity (TSA);
- a stock ownership plan;
- a *government plan*; or
- a plan that qualifies under Internal Revenue Service Code 401(k).

Social security plan means:

- the United States Social Security Act;
- the Railroad Retirement Act;
- the Canadian Pension Plan; or
- any similar plan provided under the laws of any other nation.

It also means any public employee retirement plan, or teachers' employment retirement plan provided as an alternative to rather than a supplement for such plans.

SSA representatives are persons or organizations which specialize in assisting people to obtain disability benefits under the United States Social Security Act. If you appoint an *SSA representative*, and they agree you are a good candidate, they will help you pursue your Social Security claim.

SUMMARY OF GROUP INSURANCE

This summary is intended to help understand the group insurance policy. It does not change any of its provisions.

Long Term Disability Insurance

The *policy* pays a monthly benefit designed to partly replace income lost during *periods of disability* that result from *injury*, sickness, or pregnancy.

A *covered person* who remains *disabled* during the *qualifying period* may become eligible to receive a monthly benefit based on *monthly pay*. These benefits are payable while the *disability* continues, or until the Maximum Benefit Period ends. Both the *qualifying period* and the Maximum Benefit Period are explained in the Schedule.

If a *disabled* person receives benefits from other sources, we may reduce the benefits payable under the *policy*. There are also certain disabilities for which benefits are not paid or are limited. These provisions are explained in the section entitled "LONG TERM DISABILITY INSURANCE".

The *policy* includes a conversion privilege. If a *covered person's* Long Term Disability Insurance ends, it may be possible to convert to a *conversion policy* with no health exam.

In the following pages, the provisions that describe a particular coverage were designed to be used in both the policy and the certificate. Therefore the terms "you" and "your" are used to refer to the *covered person*.

Please read
the insurance
policy carefully!

GROUP POLICY SCHEDULE

Eligible Classes:

Class I: Each active, *full-time* Partner and Attorney of the *policyholder* or an *associated company*, working in the United States of America, except any temporary or seasonal workers.

Class II: Each Of Counsel Attorney of the *policyholder* or an *associated company*, working in the United States of America, except any (i) member of Class I or (ii) temporary or seasonal workers.

Class III: Each active, *full-time* Administrator of the *policyholder* or an *associated company*, working in the United States of America, except any (i) member of Class I or Class II and (ii) temporary or seasonal workers.

Class IV: Each active, *full-time* employee of the *policyholder* or an *associated company*, working in the United

States of America, except any (i) member of Class I, Class II or Class III and (ii) temporary or seasonal workers.

Associated Companies: None

Present Service Requirement: None

Future Service Requirement: None

Entry Date: An eligible person will become insured on the day all eligibility requirements are met.

Minimum Participation Requirements:

Number – 10 Percentage – Plan I – 100%
Plan II – 85%

SCHEDULE

Long Term Disability Insurance

A *covered person* may be covered under both of the following plans. A *covered person* will be automatically covered under Plan I; however, a *covered person* may choose to be covered under both Plan I and Plan II. A person must request coverage under Plan II within 31 days after becoming eligible for insurance under the *policy*.

Schedule Amount:

Plan I: 60% of *monthly pay* subject to a maximum Schedule Amount of $1,000 per month.

Plan II: 60% of *monthly pay* subject to a maximum Schedule Amount of $5,000 per month.

For each day of a period less than a full month, the Schedule Amount will be 1/30th of the amount determined above.

Monthly pay must be from the *policyholder* or an *associated company*, is determined on the day the *period of disability* starts, and means:

For Classes I and II:

a monthly average of the amount reported as ordinary income on Schedule K-1 of IRS Partnership Return of Income Form 1065, or their successor forms, for the prior full calendar year, excluding profits, dividends or returns of capital. If you have been a member of Class I or Class II for less than a full calendar year, *monthly pay* will be the greater of a monthly average of the amount reported as ordinary income on Schedule K-1 of IRS Partnership Return of Income Form 1065, or their successor forms, during the time you were a member of Class I or Class II, or your basic monthly pay. Profits, dividends, or returns of capital will not be included.

For all other persons:

your basic monthly pay. Bonuses, commissions, overtime, and other compensation not considered by us as basic wages or salary are not included.

If you are an hourly employee, *monthly pay* will be based on your hourly rate of pay, but not on more than 40 hours per week.

Minimum Benefit: If a *covered person* normally works at least 30 hours per week before the *period of disability* starts, the minimum monthly benefit will be the greater of (i) $100 or (ii) 10% of the Schedule Amount. For any part of a *period of disability* less than a full month, the Minimum Benefit is 1/30 of the amount determined above for each day of *disability* after the *qualifying period* ends.

Qualifying Period: For a *covered person* insured under the Short Term Disability plan issued by us to the *policyholder*, the *qualifying period* is determined as follows:

- if benefits are payable under the Short Term Disability Policy for the Maximum Benefit Period, the *qualifying period* is the Maximum Benefit Period; and
- in all other cases, 3 months.

Maximum Interruption During Qualifying Period: 15 days

This Maximum applies to all returns to *active work* during any 1 *qualifying period*. However:

- the *qualifying period* will not be considered interrupted while you are in a *period of disability* under the Short Term Disability Policy; and
- the "Maximum Interruption During Qualifying Period" provisions applies only to *periods of disability* when benefits are not payable under the Short Term Disability Policy.

Maximum Benefit Period

We will not pay benefits beyond the maximums stated below, based on the person's age on the day the *period of disability* started.

AGE	MAXIMUM BENEFIT PERIOD
Before 60	the day before retirement age*
60 but before 65	the day before retirement age* or 36 months of *disability***, whichever is longer
65 but before 68	24 months of *disability***

68 but before 70	18 months of *disability***
70 but before 72	15 months of *disability***
72 or more	12 months of *disability***

*"Retirement age" means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act.

**following the end of the *qualifying period*.

ELIGIBILITY AND TERMINATION PROVISIONS

Eligible Persons

To be eligible for insurance, a person must:

- be a member of an *eligible class*; and
- complete any Service Requirement shown in the Schedule by continuous service with the employer, the *policyholder*, or an *associated company*; and
- give us *proof of good health*, if required.

The Present Service Requirement applies to persons in an *eligible class* on the Effective Date of the *policy*. The Future Service Requirement applies to persons who become members of an *eligible class* after that.

Effective Date for an Eligible Person

Any *noncontributory* insurance will take effect on the Entry Date shown in the Schedule.

For any *contributory* insurance, a person must apply for insurance on a form acceptable to us, and agree to pay part or all of the premium.

- If a person applies before becoming eligible, insurance will take effect on the Entry Date shown in the Schedule.
- If the application is made on the date the person becomes eligible, or within 31 days after that, insurance will take effect on the Entry Date occurring on or after the date of the application.
- If application is made more than 31 days after the day the person becomes eligible or after insurance ended because the premium was not paid, then *proof of good health* is required. If the proof is acceptable to us, insurance will take effect on the Entry Date occurring on or after the date the last document proving good health was signed.

Exception to Effective Date

If an eligible person is not at *active work* on the day insurance would otherwise take effect, insurance will not take effect until the person returns to *active work*. If the day insurance would normally take effect is not a regular work day for a person, insurance will take effect on that day if the person is able to do his or her regular job.

When a Person's Insurance Ends

A *covered person's* insurance will end on the date:

- the *policy* ends;
- the *policy* is changed to end the insurance for a person's *eligible class*;
- a person is no longer in an *eligible class*;
- a person stops *active work*; or
- a required contribution was not paid.

Continuance of Insurance

If a person is unable to perform *active work* for a reason shown below, the *policyholder* may continue the person's insurance. The continuance cannot be more than the maximum continuance shown below. Continuance must be based on a uniform policy, and not individual selection.

The maximum continuance for *long term disability insurance* is the longest applicable period described below:

- the Maximum Benefit Period, for *injury*, sickness, or pregnancy covered under the *policy*;
- the end of the *disability*, for *injury*, sickness, or pregnancy not covered under the *policy* because of a pre-existing condition;
- the end of the calendar month following the month *active work* stopped, for any other *injury*, sickness, or pregnancy not covered under the *policy*, or for lay-off, leave of absence (other than a family or medical leave of absence described below), or transfer to part-time; or
- the end of the period the *policyholder* is required to allow after the last day of *active work*, for a family or medical leave of absence under:
  - the federal Family and Medical Leave Act; or
  - any similar state law.

Reinstatement

If a person re-enters an Eligible Class within 12 months after insurance ends, the person will not have to complete the Service Requirement again.

LONG TERM DISABILITY INSURANCE

Insurance Provided

If you become *disabled* while insured under the *policy*, we will pay long term disability insurance benefits if you satisfy the *qualifying period*. We will continue to pay benefits during your *disability*, but not beyond the Maximum Benefit Period. Any benefits are subject to the provisions of the *policy*.

Amount of Benefit

The amount of benefit we will pay is the Schedule Amount minus the Offset Amount. However, if the Schedule Amount plus the amount of benefits and payments from Other Sources is more than 70% of your *monthly pay*, your benefit will be further reduced by the excess.

Offset Amount

If you are eligible for any of the following benefits, the total of all monthly benefits plus the pro-rated amount of any lump sum payments will be subtracted from the Schedule Amount:

- group disability benefits from any *other plan*;
- disability benefits from the United States Social Security Act, including dependent benefits, payable because of your *injury*, sickness, or pregnancy;
- disability benefits from a *government plan*, except Social Security;
- any benefits (except medical or death benefits) or any amount received in a settlement or compromise of your rights, under:

- any Workers' Compensation Act (or a similar law); or
- the Maritime Doctrine of Maintenance, Wages or Cure.

- retirement benefits, disability benefits, or similar benefits (not including your contributions) from a *retirement plan* sponsored by your employer, the *policyholder*, or an *associated company*; or
- retirement benefits from a *government plan*.

Early retirement benefits from a *retirement plan* will be included only if:

- you choose to receive them; or
- they would not reduce the normal retirement benefit under the *retirement plan* sponsored by your employer.

Other Sources

- If you are eligible to receive any salary, wages, partnership or proprietorship draw, commissions, or similar pay from any work you do, we will not consider such income for the 12 consecutive months starting on the day you become entitled to it, as long as the sum of:
  - the income described above,
  - the Schedule Amount, and
  - benefits from any source described in Other Sources,

  is not more than 100% of your *monthly pay*. If the sum is more than 100% of your *monthly pay*, we will subtract the amount over 100% from the

Schedule Amount when determining your benefit under the *policy*.

After 12 months, we will consider 70% of the amount determined after reducing any salary, wages, partnership or proprietorship draw, commissions or similar pay you earn from any work you do, by any *family care expense*.

- any group disability insurance contract, except one sponsored by your employer, the *policyholder*, or an *associated company*;
- any *no-fault motor vehicle coverage*, unless:
  - state law or regulation does not allow group disability benefits to be reduced by benefits from *no-fault motor vehicle coverage*; or
  - the *no-fault motor vehicle coverage* determines its benefits after benefits have been paid under the *policy*; or
  - the benefits are provided under optional coverage.

Estimate of Benefits

If you:

- are eligible for benefits from any of the above sources; or
- would be paid such benefits if you had applied for them or had applied for them on time;

we will figure your monthly benefit as though you are receiving these other benefits, even if you are not.

We will:

- estimate the amount of your Social Security benefit; and
- offset that amount as described above;

until we receive notice of a denial of such benefits at the first level of appeal after an initial denial.

Social Security Assistance

Your claim for Social Security disability benefits may be denied up to the reconsideration level. If it is, we will have it reviewed by an *SSA representative*, at your request.

If we consider you a good candidate, we will start this process. We will give you a list of *SSA representatives*. If you choose from this list, we will pay their fee.

Whether you use our help or not, we will reimburse you for the fee charged you by your *SSA representative*. You must become entitled to Social Security disability benefits while eligible for benefits under our *policy*. Our reimbursement is limited to the fee approved by the Social Security Administration. We may reduce any overpayment calculated in our claim.

Adjustment of Benefits

If we find that the amount of benefits from any source should be different from the amount we used to figure your monthly benefit, we will adjust it.

If we paid you less than we should have, we will pay you the difference.

If we paid you more than we should have, you must pay us the difference. We may reduce your benefit or stop paying benefits until the overpayment is recovered. If we reduce your benefit, or stop paying benefits, the Minimum Benefit will not be payable.

We may also reduce or stop paying benefits until any overpayment made to you under the Short Term Disability plan issued by us to the *policyholder* is recovered. If we reduce your benefit, or stop paying benefits, the Minimum Benefit will not be payable.

Lump Sum Benefit

If you receive benefits from any source in a lump sum, we will pro-rate it over the time in which it accrued, based on information from the source of the payment. If we do not receive all the information we need, we will pro-rate the payment according to its nature and purpose.

Benefit Freeze

We will not reduce your monthly benefit further if the amount of benefits from any source, other than the *policy*, changes because of a cost of living increase that occurs automatically or by law after you satisfy the *qualifying period*.

Rehabilitation Benefit

Rehabilitation Plan for You

You may ask to participate in a *rehabilitation plan* while you are *disabled*. We have the sole discretion

to approve or deny your request. The terms and conditions of the *rehabilitation plan* must be mutually agreed upon by you and us.

While you are participating in your *rehabilitation plan*, we will increase your Schedule Amount by 5% of your *monthly pay* or $1,000, whichever is less. During this period, your Schedule Amount may exceed the maximum Schedule Amount in the Schedule.

The *rehabilitation plan* may include, at our discretion, payment of your *medical expense, education expense, moving expense, accommodation expense or family care expense.*

If you return to work as part of a *rehabilitation plan* while you are *disabled*, we will pay your employer:

- 50% of your salary, wages, partnership or proprietorship draw, commissions, or similar pay; or
- the Schedule Amount, if less,

for the first month after you return to work, or your remaining *period of disability*, if less.

If your *disability* ends while you are participating in your *rehabilitation plan*, and you are not able to find gainful work, we will:

- pay you the amount of benefit, other than rehabilitation benefits, that would have been payable to you if you had remained *disabled* until:
  - 3 months after your *disability* ends, or
  - the date you are able to find gainful work, if earlier; and
- provide or pay for reasonable job placement services for a period of up to 3 months after your *disability* ends.

Rehabilitation Plan for your Spouse

You and your spouse may ask to participate in a *rehabilitation plan* for your spouse while you are *disabled* if:

- you are receiving disability benefits from a *social security plan*, and
- your spouse's earnings in the six calendar months prior to your *disability* averaged less than 60% of your *monthly pay*.

We have the sole discretion to approve or deny your request. The terms and conditions of the *rehabilitation plan* must be mutually agreed by you, your spouse and us.

The *rehabilitation plan* for your spouse may include, at our discretion, payment of your spouse's *education expense*, reasonable job placement expenses, and the family's *moving expense*, if any. It may also include *family care expense* incurred by your spouse, necessary in order for your spouse to be retrained under the *rehabilitation plan*.

We will reduce the amount of your benefit we pay you by 50% of any salary, wages, partnership or proprietorship draw, commissions, or similar pay from any work your spouse does as a result of participating in your spouse's *rehabilitation plan*. If your spouse is working when your spouse's *rehabilitation plan* begins, we will only reduce your benefit by 50% of the increase in income that results from your spouse's participation in your spouse's *rehabilitation plan*.

Exclusions

We will not pay benefits for any time you are confined to any facility because you were convicted of a crime or public offense.

We will not pay benefits for any *disability* caused by:

- war or any act of war, whether declared or not;
- intentionally self-inflicted injury, while sane or insane; or
- taking part in or the result of taking part in committing an assault or felony.

Mental Illness

We pay only a limited benefit for *periods of disability* for *mental illness*. The Maximum Benefit Period for all such *periods of disability* is 24 months. This is not a separate maximum for each such condition, or for each *period of disability*, but a combined maximum for all *periods of disability* and for all of these conditions.

Benefits may be payable for more than 24 months, but not beyond the Maximum Benefit Period in the Schedule, if you

- are *hospital confined* at the end of the 24-month period above, and
- remain *disabled*.

Benefits will be payable for the length of your confinement and for up to 60 days following the end of your confinement.

If you are *hospital confined* again during the 60-day period for at least 10 consecutive days, benefits will be payable

for the length of the second confinement and for up to 60 days following the end of the second confinement.

Pre-Existing Conditions

We will not pay benefits for any *disability* caused by a pre-existing condition (defined below) until the earlier of:

- 3 consecutive months, ending on or after the day you became insured under the *long term disability insurance policy*, during which you do not consult with or receive advice from a licensed medical or dental practitioner or receive medical or dental care, treatment, or services, including taking drugs, medicine, insulin, or similar substances, for that condition; or
- 12 consecutive months during which you are continuously insured under the *long term disability insurance policy*.

A "pre-existing condition" means an *injury*, sickness, or pregnancy or any related *injury*, sickness, or pregnancy for which you:

- consulted with or received advice from a licensed medical or dental practitioner; or
- received medical or dental care, treatment, or services, including taking drugs, medicine, insulin, or similar substances

during the 3 months that end on the day before you became insured under the *long term disability insurance policy*.

Extended Benefit

If you are *disabled* on the day your *long term disability insurance* ends, and if you remain *disabled* long enough to qualify, we will pay benefits according to the *policy*.

Conversion Privilege

If your *long term disability insurance* ends, you may be able to convert to coverage provided under a conversion policy. You must have been insured under the *policy* for at least a year. This includes time insured under any similar group policy which the *policy* replaces.

Within 31 days after your insurance ends, you must:

- apply for coverage under the conversion policy; and
- pay the first premium.

Proof of good health is not required.

You cannot convert if your *long term disability insurance* ends because:

- the *policy* ends;
- the *policy* is changed to end your coverage;
- you are *disabled*;
- a required premium is not paid; or
- you retire from your employer, the *policyholder*, or an *associated company*.

The benefits of the conversion policy will be those we offer for conversion at the time you apply. The premium will be based on rates in effect for conversion policies at that time.

The effective date of coverage will be the day after your insurance under the *policy* ends.

Survivor Benefit

If you die while entitled to benefits under the *policy*, we will pay a survivor benefit. We must receive proof of your death and proof that the person claiming the benefit is entitled to it. We will pay the survivor benefit only to your lawful spouse, if living, otherwise, to your children. Children must be unmarried, and under age 21 or, if a full-time student, age 25. "Children" include step-children or foster children that depended on you for support and maintenance. Adopted children are also included. If no one entitled to the survivor benefit is living on the first of any month after your death, we will pay the balance of the survivor benefit to your estate.

The monthly survivor benefit equals the monthly benefit payable under the *policy* for your last full calendar month of *disability*. If no benefit was paid for a full calendar month, a survivor benefit for a full month will be determined.

The survivor benefit is payable on:

- the first of the month after your death; and
- the first of each of the next 5 months.

Accelerated Survivor Benefit

If you submit a request, and meet the following requirements, we will pay you an accelerated survivor benefit. This benefit is paid in addition to the regular *long term disability* benefit.

You must:

- be diagnosed by a *doctor* with a *qualifying medical condition*;
- have satisfied the *qualifying period*;
- have been awarded disability or retirement benefits under a *social security plan*; and
- be living on the date of payment of the accelerated survivor benefit.

You must submit any information necessary to determine our liability.

The accelerated survivor benefit equals 6 times the monthly amount of *long term disability* benefit payable under the *policy* for the last full calendar month of *disability* prior to the date of your request. It will be paid in a single sum to you.

Payment of the survivor benefit or the accelerated survivor benefit is subject to the other provisions of the *policy*. If an accelerated survivor benefit has been paid, no survivor benefit will be payable.

CLAIM PROVISIONS

Payment of Benefits

We will pay benefits at the end of each month (or shorter period) for which we are liable, after we receive the required proof. If any amount is unpaid when *disability* ends, we will pay it when we receive the required proof.

To Whom Payable

We will pay all benefits to you, if you are legally competent. If you are legally incompetent, we will pay benefits to the guardian of your estate. If any amount remains unpaid when you die, we will pay your estate.

Filing a Claim

1. You must send us notice of the claim. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, to one of our regional group claims offices, or to one of our agents. We need enough information to identify you as a *covered person*.

2. Within 15 days after the date of your notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or to one of our regional group claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

3. The time limit for filing a claim is 90 days after the end of the first month (or shorter period) for which we are liable.

4. To decide our liability, we may require:

   - proof of benefits from other sources, and
   - proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

You must furnish whatever items we decide are necessary as proof of loss or to decide our liability. You must authorize the sources of medical and dental services to release

your medical information. If you do not furnish any required information or authorize its release, we will not pay benefits.

If it is not reasonably possible to give proof on time, we will not deny or reduce your claim if you give us proof as soon as reasonably possible.

Physical Exam

We may ask you to be examined as often as we require at any time we choose. We will pay for any exam we require.

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations in your state has expired, but, in any case, not after 6 years.

GENERAL PROVISIONS

Entire Contract

The *policy* and the *policyholder's* application attached to it are the entire contract. Any statement made by you or the *policyholder* is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end.

We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about a person is misstated, the facts will determine whether insurance is in effect and in what amount. We will equitably adjust the premium.

Individual Certificates

We will send certificates to the *policyholder* to give to each *covered person*. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the *policy*.

Workers' Compensation

The *policy* is not in place of, and does not affect any state's requirements for coverage by Workers' Compensation insurance.

Agency

Neither the *policyholder*, any employer, any *associated company*, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Changing the Policy

The *policyholder* owns the *policy*. The *policy* may be changed at any time by an endorsement or amendment agreed upon by the *policyholder* and us. A change must be approved by one of our executive officers. No agent can change the *policy* or waive any of its provisions.

Required Data

The *policyholder* must give us all data needed to administer the insurance and determine premiums. The *policyholder* must also give us any other information we require. We may inspect the *policyholder's* records relating to the insurance provided by the *policy*.

Policyholder's Assignment

The *policyholder* may assign the *policy*. This will not affect the rights of any *covered person* or *beneficiary*. We will not be responsible for the validity of any assignment. We must receive written notice of an assignment at our *home office*.

When the Policy Ends

The *policy* will end on the date:

- the grace period ends, if the premium has not been paid; or
- we receive written notice from the *policyholder*, or the date shown in the notice, whichever is later.

The *policy* will also end if the number or percentage of persons covered under the *policy* does not meet the Minimum Participation Requirements shown in the Schedule.

If the Participation Requirements are not met, we will notify the *policyholder* 31 days in advance that insurance will end. We consider that notice is given when delivered or mailed to the last known address of the *policyholder*.

If the date the *policy* ends is not the same as the date to which premiums have been paid, the difference in premium:

- must be paid to us, if underpaid; or
- will be refunded by us, if overpaid.

PREMIUMS

Premium Payments

The *policyholder* must pay all premiums in advance at our *home office* or to one of our agents. The *policyholder* may request on any policy anniversary that the frequency of premium payment be changed to annually, semi-annually, quarterly, or monthly.

Grace Period

If any premium is not paid when due, the *policy* will be in default on that date. The *policyholder* has a grace period of 31 days after that date to pay the premium. In any case, the *policyholder* must pay the premium for coverage in force during the grace period.

Calculation of Premiums

The first premium is due on the effective date. Future premiums are due on each premium due date. The premium is based on the premium rate and the amount of

insurance. We will furnish premium rates to the *policyholder* with an explanation of how to apply them. If the frequency of premium payment is not monthly, each premium after the first will be adjusted. This will be based on the completed months of coverage for insurance that took effect and the insurance that ended during the previous premium period.

No premium is due for a person who is entitled to receive *long term disability insurance* benefits.

Our Right to Change Premium Rates

We may change the premium rate:

- after the second policy anniversary; or
- when our liability changes.

Unless our liability changes:

- we will not change the rates more than once in any period of 12 consecutive months; and
- we will give the *policyholder* 31 days advance written notice of an increase in rates.

ENDORSEMENTS AND AMENDMENTS

APPLICATION

fortis

Fortis Benefits
Insurance Company
St. Paul, Minnesota • Kansas City, Missouri

to Fortis Benefits Insurance Company

by Crowley, Haughey, Hanson, Toole & Dietrich

for group policy no. G 71,216

This application is executed in duplicate. One copy is to be attached to the *policy*. The other is to be returned to Fortis Benefits.

It is agreed that this Application replaces any prior application for the *policy*.

10 or more lives must be insured on the Effective Date of the *policy*. In addition, the number of lives to be insured on that date must be Plan I – 100%, Plan II – 85% of those eligible for insurance at that time.

Crowley, Haughey, Hanson, Toole & Dietrich
(Full or Corporate Name of Applicant)

by _____
(Signature and Title)

Signed at _____ Date _____

Witness _____

(To be signed by Resident Agent where required by law)

[This copy is to remain attached to the *policy*.]

GPA-90 LTD/JMD/10

APPLICATION

fortis

Fortis Benefits
Insurance Company
St. Paul, Minnesota • Kansas City, Missouri

---

to Fortis Benefits Insurance Company

by Crowley, Haughey, Hanson, Toole & Dietrich

for group policy no. G 71,216

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Crowley, Haughey, Hanson, Toole & Dietrich
(Full or Corporate Name of Applicant)

by _____
(Signature and Title)

Signed at _____ Date _____

Witness _____
(To be signed by Resident Agent where required by law)

[This copy must be returned to the *home office*.]

GPA-90 LTD/JMD/10

Fortis Benefits
Insurance Company
2323 Grand Boulevard
Kansas City, MO 64108
(816) 474-2602

GROUP UNDERWRITING & ADMINISTRATION

Re: Special consideration for those people who were insured under your prior plan(s)

Dear Employer:

In order to provide continuity of coverage for people who were covered under your prior plan of group insurance on the last day that it was in effect (which must be the day immediately preceding the effective date of your coverage with our Company) and who might otherwise be deprived of coverage because of certain requirements contained in our group *policy*, Fortis Benefits agrees to the liberalizations described in the attachment with the following stipulations:

- In order to apply these liberalizations, we ask that you provide a copy of the group policy(ies) issued by your prior insurer(s) *or* a copy of an employee certificate showing the full group coverage previously in effect.

- Payment on each claim under the basis described above will be contingent upon (a) satisfactory proof that the claimant was insured under your prior group coverage on the date that it terminated, (b) your furnishing us with whatever data is necessary to administer claims on the basis described above, and (c) authorizing your prior insurer to furnish us with whatever information may be requested.

VERY IMPORTANT

The prior carrier should be notified immediately of all employees disabled on the effective date of our plan. Any such employee may qualify for coverage under the extension of benefits/waiver of premium provision(s) of the prior plan of insurance. Your Fortis Benefits Group Representative should be contacted if you have questions concerning *any* employee who is not at work on the effective date of our plan.

Since very few individuals will be affected by these liberalizations, we will not amend the group *policy*. Except for the liberalizations contained in the attachment, the group *policy* contains the full details of the coverage we are providing. We do suggest that you *keep this letter and the attachment with your group policy/Application* for ready reference.

We are furnishing you with a supply of Certificate Notices for each coverage elected *except* Life and/or Dental. *Please distribute* these Certificate Notices when you receive the certificates. *Only* those people who were insured under your prior carrier's group plan on the date it terminated should receive this Notice with their certificates.

We have previously requested the name of any employee not actively at work on the effective date of our plan, and do not require premium for any such employee while *disabled*, except for dental insurance.* If the employee returns to *active work*, an enrollment card should be completed at once to become insured under our plan(s) of Life and/or Short Term Disability and/or Long Term Disability Insurance. This is particularly important if the employee is required to contribute to the cost of the Group

Insurance, since failure to do so will result in a gap in coverage. Also, failure to enroll within 31 days of the date of his or her return to *active work* will result in the employee having to furnish *proof of good health* before he or she will be covered under our Group Insurance coverage.

* Premium is required for any employee while on a leave of absence.

If you have any questions, please do not hesitate to contact us.

Sincerely,

/s/ D P Pitrelli
Domenic P. Pitrelli
Senior Vice-President

ATTACHMENT

Applicable to Group Long Term Disability Insurance

Each employee who was covered under your prior plan of group long term disability insurance on the last day that it was in effect (which must be the day immediately preceding the effective date of your coverage with our Company), will be covered by Fortis Benefits as follows:

1. Each employee who is eligible to become insured under our group *long term disability insurance* coverage (i.e., is at *active work*) will become insured under our group *long term disability insurance* coverage on the effective date.

2. Each employee who, solely because of an existing *disability*, is not eligible to become insured under our group *long term disability insurance* coverage, will be covered by us and be provided the long term disability

insurance benefits for which he or she was eligible under the prior plan until the earlier of:

- the date he or she satisfies our *active work* requirement for *long term disability insurance* coverage, or
- the end of the period of extension or accrued liability of the prior plan.

3. Each employee who

   - is not at *active work* on the effective date of our coverage, *and*
   - is not *disabled* on the effective date of our coverage (i.e., leave of absence), *and*
   - would otherwise be eligible to become insured under our plan,

   will be covered by us and be provided the long term disability insurance benefits for which he or she was eligible under the prior plan until the earlier of:

   - the date he or she satisfies our *active work* requirement for *long term disability insurance* coverage,
   - the date his or her *long term disability insurance* coverage would otherwise have terminated according to any continuance provisions of the prior plan (for example, the end of any period of leave of absence), or
   - the date his or her *long term disability insurance* coverage would otherwise have terminated according to our individual termination of coverage provisions (for example, the date of termination of employment).

Any benefits payable under 2 and 3 above will be paid as if the prior plan had remained in effect and reduced by any benefits paid or payable by the prior plan.

4. The definition of *period of disability* in your *policy* describes the conditions that must be met for two or more *disabilities* to be considered as having occurred during one *period of disability*. This allows the employee to avoid having to satisfy a separate *qualifying period* for each *disability*. We will apply this provision to an employee who

   - received benefits under the prior plan, and
   - becomes *disabled* again while insured under our plan

   just as though our coverage had been in effect since the date the employee first became *disabled*.

5. The benefits payable for *disability* due to a pre-existing condition are limited until certain requirements are satisfied. For any *disability* which would be excluded during the period of time this limitation applies, we will provide the lesser of:

   - the benefits of our plan without the pre-existing conditions limitation, and
   - the benefits of the prior plan (applying the prior plan's pre-existing conditions limitation, if any) just as if it had remained in effect.

Effective January 1, 1995, the *policy* is changed as follows:

The "**Eligible Classes**" provision in the **GROUP POLICY SCHEDULE** has been changed to read as follows:

Eligible Classes: Each active, *full-time* employee of the *policyholder* or an *associated company*, working in the

United States of America, except any (i) Partners or Attorneys, (ii) Office Manager and Office Manager Assistant, (iii) Para-legal or any (iv) temporary or seasonal workers.

ENDORSEMENTS AND AMENDMENTS

Effective November 1, 1997, the group *short term disability insurance* policy(ies) issued to the *policyholder* by Fortis Benefits Insurance Company shall be modified as follows:

The Claims Provision section is changed by the addition of the following:

Authority

We have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by us are conclusive and binding on all parties.

PC-ALL-62-94 /s/ Robert R. [Illegible] Secretary /s/ [Illegible] President

EXHIBIT D

CROWLEY, HAUGHEY, HANSON, TOOLE & DIETRICH, P.L.L.P.
ATTORNEYS AT LAW
ESTABLISHED 1895

[Address Omitted In Printing]

October 17, 2000

Fortis Benefits
PO Box 39844
Minneapolis, MN 55439-0844

RE: Stephanie L. Elliot Long Term Disability Claim

To Whom It May Concern:

Enclosed is the completed claim form for long term disability benefits for our Paralegal (Legal Assistant), Stephanie L. Elliot. Please be advised that our Paralegals (Legal Assistants) are insured for long-term disability benefits only, not short-term. Stephanie's last day of work was August 18, 2000 and her salary from the law firm is continued at 100% for the first 90 days of disability (through November 20, 2000). After 90 days, Fortis long-term disability benefits begin.

Please let me know if you have any questions about the enclosed claim or need any further information. My direct phone number is 406-255-7315. Thank you.

Sincerely yours,

CROWLEY, HAUGHEY, HANSON,
TOOLE & DIETRICH, P.L.L.P.

Cindy Kratochvil
Administrative Assistant

Donald L. Harris
COZZENS, WARREN & HARRIS, P.L.L.P.
550 North 31st Street, Suite 250
Billings, MT 59101
Telephone: (406) 294-2000

Attorneys for Plaintiff

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
BILLINGS DIVISION**

Stephanie Elliot, Plaintiff, v. Fortis Benefits Insurance Company, Defendant.	)	Cause No.: CV 01-11-BG JDS **AFFIDAVIT OF DR. NEEL HAMMOND**
STATE OF MONTANA County of Missoula	) : SS)	

I, DR. NEEL HAMMOND, being first duly sworn, upon oath state:

1. I am Dr. Neel Hammond. I received my medical degree from University of Miami School of Medicine and I am Board Certified in Internal Medicine and Medical Oncology. I have been licensed to practice medicine in the state of Montana since 1977. I practiced medicine with Billings Oncology Associates in Billings, Montana for 23 years from 1977 to 2000. I retired from the practice of medicine on June 30, 2000. I am currently attending law school at the University of Montana School of Law in Missoula, Montana.

2. Stevie Elliot was a patient of mine from July 1997 through June 2000. During that time, I examined Ms. Elliot and had her undergo thorough testing to determine whether she had cancer. The examinations and tests were conducted approximately every three months. Based upon those examinations and test results, it was and is my professional medical opinion to a reasonable degree of medical certainty that Ms. Elliot did not have cancer or any sickness or disease related to cancer between July 1997 and June 2000.

3. I did prescribe the drug Tamoxifen for Ms. Elliot to take during the time she was my patient. I prescribed Tamoxifen for prophylactic purposes. Tamoxifen has been shown to help prevent cancer in women who are at high risk for developing breast cancer. Ms. Elliot was considered to have a high risk of developing breast cancer because she had had breast cancer in the past before she became my patient. Even though Ms. Elliot had fully recovered from that cancer, statistically Ms. Elliot was considered to have a high risk of developing cancer in the future. Studies have shown that women who are at a high risk of developing breast cancer have significantly better chances of not developing cancer in the future if they take Tamoxifen.

4. I did not prescribe Tamoxifen for Ms. Elliot because she was suffering from cancer. I prescribed Tamoxifen to lessen the chances that Ms. Elliot would develop cancer in the future. There was no medical evidence that Ms. Elliot had cancer during the time she was my patient.

5. I understand from reviewing Ms. Elliot's medical records that Ms. Elliot did develop cancer which was

diagnosed by my former partner, Dr. Patrick Cobb, in August 2000. There is no medical basis for inferring that, because Ms. Elliot had cancer in August 2000, she must have had cancer in the spring or summer of 1999. None of the tests and examinations which Ms. Elliot underwent during the spring and summer of 1999 showed any indication of cancer.

DATED this 30th day of May, 2001.

/s/ Neel Hammond
DR. NEEL HAMMOND

SUBSCRIBED AND SWORN to before me this 30th day of May, 2001.

(NOTARIAL SEAL)

/s/ Diana B. Hodges
Notary Public for the State of Montana, Residing at Missoula, Montana.
My commission expires: 08-10-2003

[LOGO]
FORTIS
Solid partners, flexible solutions™

October 30, 2000
Stephanie Elliot
2525 Orchard Dr
Billings, MT 59102

[Address Omitted In Printing]

RE: Your Long Term Disability Claim
LTD Policy #71216-0-0-108

Dear Mrs. Elliot:

Due to the proximity of the onset of your disability to your disability coverage effective date, we must conduct a routine pre-existing condition investigation. Please refer to the section of your policy entitled "Pre-existing Conditions" which states:

Pre-Existing Conditions

We will not pay benefits for any *disability* caused by a pre-existing condition (defined below) until you have been at *active work* for a full day following the earlier of:

- 3 consecutive months, ending on or after the day you became insured under the *long term disability insurance policy*, during which you do not consult with or receive advice from a licensed medical or dental practitioner or receive medical or dental care, treatment or services, including taking drugs, medicine, insulin, or similar substances, for that condition; or
- 12 consecutive months during which you are continuously insured under the *long term disability insurance policy*.

A "pre-existing condition" means an *injury*, sickness, or pregnancy or any related *injury*, sickness, or pregnancy for which you:

- consulted with or received advice from a licensed medical or dental practitioner; or
- received medical or dental care, treatment, or services, including taking drugs, medicine, insulin, or similar substances

during the 3 months that end on the day before you became insured under the *long term disability insurance policy*.

The effective date of your long term disability coverage was September 27, 1999. Your onset date of disability is August 19, 2000. As your coverage was not effective for a 12 month period prior to being unable to perform your occupation, we must conduct a routine pre-existing review.

To do so, we will require medical and pharmacy records from all providers since June 27, 1999. Please provide the complete names, addresses, and phone numbers for all physicians or therapists you have treated with and all pharmacies you have received prescription medications from since July 27, 1999. A postage-paid envelope is enclosed for your response.

I would like to discuss our review of your claim with you and answer any questions you may have. Please call me at your earliest convenience if we haven't yet spoken by the time of your receipt of this letter.

Thank you,

Alexander MacGillis
Disability Claims Specialist
(800) 325-8385 x-2955
agmacgillis@us.fortis.com

enc.
cc: Cindy Kratochvil, Crowley, Haughey, Hanson, Toole & Dietrich

June 8, 2000

Brock Whittenberger, M.D.

DEACONESS BILLINGS CLINIC

P.O. Box 37000

Billings, MT 59107-7000

RE: STEPHANIE ELLIOTT

Dear Brock:

Stephanie Elliot is a patient of mine who I originally saw in August of 1997 with a history that is well outlined on my note of entry of August 21, 1997. She has a protracted history including treatment with anthracyclines and an autotransplant done at Duke University in 1996. She had bony metastases at that time that were not documented histopathologically but were present on bone scan and plain films. Stevie in the three years I have followed her has remained disease free. I have recently obtained CA 27.29 values because of her previous bony involvement and noted some elevation of those values despite negative studies otherwise. In retrospect, I think that was an isolated chemical abnormality and has nothing to do with any recrudescence of her disease. Stevie does work for the Crowley Law Firm and I think as a matter of future insurance needs to be followed in the Deaconess system. She is positively familiar with you. Stevie is a wonderful lady who has been through a great deal and who is appropriately frightened because of her history.

I think you will find caring for Stevie to be a real pleasure. I do hope our records are adequate. If not, please feel free

to get back to us and we will supply you with whatever additional data you may need.

Sincerely,

Neel Hammond, M.D.

NH:nas

Enclosure

cc Mary, R.N. June 9, 2000 /s/ NAS